THE REGULATED HEALTH PROFESSIONS ACT AND DENTAL HYGIENE

A STUDY OF THE CHANGING SOCIAL ORGANIZATION OF HEALTH CARE DELIVERY IN ONTARIO

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To the memory of my parents, Lucy Louise Gates McIntosh and George Kennedy McKeown whose union, life experiences and guidance laid the foundation for this project.

ABSTRACT

Has the new health legislation, the Regulated Health Professions Act, 1994, changed the social organization of health care delivery in Ontario? My research has shown that this new legislation, which governs twenty-four health professions, is a site of power relations.

The seemingly mundane and ordinary practice of oral health care delivery is examined to find evidence of change in the social organization of health care. The relationship between two providers of services surrounding the mouth and oral health care, dental hygiene and dentistry exemplify the power relations and the inherent resistance emerging as the legislation is enacted. The evidence at this time indicates that the existing professional monopolies may not be disrupted easily, even with new legislation. The themes that emerged from the struggle to reframe the relations between dentistry and dental hygiene under the new R.H.P.A. are: discourse/language, professional dominance, technologies of bureaucracy, gender, and power/knowledge.

ABSTRACT

Has the new health legislation, the Regulated Health Professions Act, 1994, changed the social organization of health care delivery in Ontario? My research has shown that this new legislation, which governs twenty-four health professions, is a site of power relations. Part of the intent of the R.H.P.A. was to increase the accountability of professionals and to increase the consumer's ability to access affordable options for health care.

Michel Foucault provides this researcher with a way to examine the initial impact of the R.H.P.A. He respects differences and acknowledges exclusion in discourse as he analyzes modernity from various perspectives. He thinks and conceptualizes power as diffused through multiple social sites, as something that is exercised, not as something such as a position that is held in a hierarchical structure. Foucault insists on a close connection between power and resistance. Resistance is not external to power but inherent to power relations.

Using personal experience of the professional self-governing process and Foucault's approach to power relations, the seemingly mundane and ordinary practice of oral health care delivery is examined to find evidence of change in the social organization of health care. The relationship between two providers of services surrounding the mouth and oral health care, dental hygiene and dentistry exemplify the power relations and the inherent resistance emerging as the legislation is enacted. Dental hygiene is struggling to attain autonomy and is advocating for more interdependent provision of health services and the public's freedom to choose their access point to preventive oral health services. Dentistry is struggling to preserve the 'status quo.' A 'tug of war' is taking place between the implementation of more community based, preventive services of interrelated health care providers, and the preservation of the traditional, independent, fee-for-serve treatment practices. However, legislation has legitimized and enabled many emerging professions such as dental hygiene to voice their concerns through open consultations and public forums.

The evidence at this time indicates that the existing professional monopolies may not be disrupted easily. Thus, distribution of non-traditional health care providers to alternate practice settings in urban communities or Northern, remote and rural areas, is not an immediate result of the passing of this new legislation. The themes that emerged from the struggle to reframe the relations between dentistry and dental hygiene under the new R.H.P.A. are: discourse/language, professional dominance, technologies of bureaucracy, gender, and power/knowledge.

GLOSSARY OF ACRONYMS

The following acronyms have been used in the text.

R.H.P.A.	Regulated Health Professions Act, 1994
H.P.L.R.	Health Professions Legislative Review
M.O.H.	Minister of Health
A.D.M.	Assistant Deputy Minister
P.R.B.	Professional Relations Branch (reports to A.D.M. and .M.O.H.)
H.D.A.	Health Disciplines Act (prior to R.H.P.A.) Revised Statute of Ontario 198 Chpt. 196., 1976
D.H.A.	Dental Hygiene Act, 1991
H.P.R.A.C.	Health Professions Regulatory Advisory Council who provides arms-length, non-binding advice to the Minister of Health on issues concerning the regulation of health professionals. The Council is composed of 7 members from outside government, the civil service, and the health professions.
C.D.H.O.	College of Dental Hygienists of Ontario
R.C.D.S.O.	Royal College of Dental Surgeons of Ontario
C.N.O.	College of Nurses of Ontario
O.D.A.	Ontario Dental Association
O.D.H.A.	Ontario Dental Hygiene Association

CHAPTER 1:
INTRODUCTION

This research was initiated to determine what effect new health legislation has on the social organization of health care delivery in Ontario. Does the Regulated Health Professions Act, 1994 in fact change the social organization of health care delivery in Ontario? As the research progressed, it became evident that there is a division between the changes for the newly regulated providers and the changes for consumers. There is a definite change in social organization for the providers with the introduction of the R.H.P.A. Legislation has legitimized and enabled many emerging professions, such as midwifery, nursing and dental hygiene, to voice their concerns through open consultations and public forums. Also, it has become apparent that the existing professional monopolies may not be ruptured easily and that the distribution of non-traditional health care providers to alternate delivery settings in urban communities or in Northern, remote and rural areas will not be immediate and will require consumer advocacy for freedom to choose previously unavailable or inaccessible health care services.

As a participant observer, knowledgeable and experienced in the regulatory process, qualitative research is the method chosen for this study. Using personal experience and Foucault's approach to power relations and the inherent resistances, a seemingly mundane and ordinary practice, oral health care delivery, is explored. The study provides an opportunity to look at constrasting perceptions regarding practices surrounding the mouth.

The Regulated Health Professions Act, 1994, new health legislation in the province of Ontario, proclaimed December 31, 1993, is a site of power relations and health politics. Included with this legislation are twenty-one profession specific Acts regulating twenty-four health occupations (Appendix A). Many of these health occupations are independently regulated for the first time. This study takes the new legislation as a starting point and also looks at pre-proclamation events such as previous health legislation and the findings of the Health Professions Legislative Review. The R.H.P.A. and the twenty-one profession specific Acts establish a whole series of power networks that invest in the body.

For the purpose of this study, dentistry and dental hygiene are used as examples of resistance and, thus, new power relations that are occurring with this new professional regulatory legislation. Gross has stated that:

> ... changes in licensing regulations that enhance competition and accountability will create other changes which will shape professional services to raise quality, reduce cost, and increase public self-protection (Gross, 1984: xii).

Looking at dental hygiene's attempt to regulate itself independently of dentistry provides, for this researcher, a starting point and a point from which to stand. As the regulatory body of dental hygiene (the College of Dental Hygienists) attempts to have the word 'order' removed for prophylaxis, the non-contraindicated procedures of scaling and root planing, the possibility for change in the social organization of health care delivery and the opposition and resistance to the 'status quo' emerge. These two health occupations provide a contrast between dental hygiene, an emerging preventive/health promotion, wellness-oriented health care provider, and dentistry, an established, curative medical treatment-focused health care provider. These two valued perspectives openly clashed as both regulatory bodies prepared for proclamation of new health legislation. The study focuses on dentistry's attempt to maintain control of dental hygiene through dentistry's interpretation of the word 'order' in its regulations, and dental hygiene's resistance to continued subordination by its attempt to amend the Dental Hygiene Act. It will be shown that this struggle indicates a change in the social organization of health care delivery for providers.

Hopefully, this new regulatory system for health care professionals will result in positive changes in health care delivery. It is possible that the way society thinks and perceives of health care in general and oral health care in particular could be so different in the future that it would be unrecognizable from this present stand point. I present my perspective to avoid any misinterpretation by the reader.

Independent regulation for dental hygiene means increased accountability and autonomy. My perspective is that this autonomy does not mean freedom to be entrepreneurs nor freedom to reproduce the established traditional patterns of hierarchy and patriarchy, rather it is freedom to form new alliances and to work in non-traditional practice settings. The freedom to form new alliances with health care professionals such as nutritionists, chiropodists, massage therapists, nurses, etc., could provide the opportunity to re-establish the link between the mouth, the gateway to the body and the rest of the person. Good oral health is inextricably linked to good general health. Oral health is not just a matter of apperance. The mouth is essential to speech and the digestive system. Poor oral conditions affect social interaction and apperance and contribute unnecessarily to pain and erode the individual's morale and overall attitude. Oral health problems can have significant consequences on an individual's general health and quality of life. However, the present funding system appears to separate the mouth from the rest of the body. Countries such as Norway, Sweden and Scotland recognize that oral health is important to total health and include oral health in publicly funded health care programs.

I see a collaborative approach to health care, one which includes a "circle" of providers of care, not a "ladder" or hierarchy of curative treatment providers. This freedom will enable and empower providers to work interdependently in their preferred location with other health care providers of their choice. I conceive these alliances perhaps in community health centres, to be a new version of the "old time" family physician who knew and understood the family with all of its interactions and its social, spiritual, physical and emotional components. The body and person will be recognized as a unified whole, connected to the external environment. The various health care providers will collaborate with each other and the client in attempts to achieve good health and total well-being. So, it is my hope that clients will have the freedom to choose health care providers in appropriate practice settings in all communities in all parts of the province.

Discourse/language can be effective in changing the public's perception and awareness of certain practices within society. However, discourse/language can also perpetuate established traditions of power/knowledge. The word 'order' is an example. The word 'order' is included in a few, mainly female dominated, profession specific Acts. The word 'order' in the Dental Hygiene Act acts as a catalyst which reveals two different and valued perspectives, dentistry (treatment) and dental hygiene (prevention). The word 'order' carries with it historical, military language (Appendix B). It is a coded sign of obedience. It is a word that traditionally differentiates values and levels of knowledge. Thus, the inclusion of the word 'order' is questionable in new health legislation as it is impregnated with professional dominance, power, and the privileges of specialized knowledge, technologies of bureaucracy, and gender inequities.

The social organization of oral health care is generally considered a rather ordinary and mundane practice. However, looking at this rather mundane practice provides the opportunity to observe speech and language practices that surround the mouth. It becomes evident to this researcher that the mouth and its care are examples of the way power is exercised.

The research reported here shows that this new, multi-health occupational legislation is a site of power relations with their inherent resistances. The relationship between two providers of services surrounding the mouth and oral health care, dentistry, and dental hygiene exemplify power relations and sites of resistance. Related themes and patterns emerge. The central themes discussed are: discourse/language, professional dominance, technologies of bureaucracy, gender, and power/knowledge.

CHAPTER 2:
METHODOLOGY

As a participant, I was actively involved in the discussions which comprise much of the data. As a student preparing to develop a thesis, I studied articles regarding the regulation of professions, dental care or lack of it in various countries, and sociological theories. In undertaking this research project, I applied the academic materials to the living experience.

Discourse is central to this thesis as the study of speech and language in the official documents, meetings, submissions and correspondence reveals particular themes. These themes and patterns are supported by theory in the academic literature.

Thesis Question

"Does enactment of the Regulated Health Professions Act change the social organization of health care delivery?" As the research progressed, it became evident that there are two aspects to this question. One involves the providers of services and the other involves the consumers. On one level, the change in the social organization of health care delivery is evident as the new, independently regulated providers such as dental hygiene are enabled through the legislation to publicly contest and resist established practices. However, it is not yet clear whether the new legislation will enhance competition, nor whether consumers of health care services will have increased access to available and affordable services of their choice, or whether the newly regulated professions will be permitted to provide services in non-traditional practice settings.

Parameters of the Study

The parameters of the study are the pre-proclamation period between November 1992 and December 31, 1993, and, the post-proclamation period of January 1, 1994, to April 30, 1995.

Qualitative Analysis

Qualitative data analysis is systematic and logically rigorous. It looks for patterns or relationships. There is no statistical analysis as the data is not in the form of numbers, but in the form of words:

> Words are not only more fundamental intellectually; one may also say that they are necessarily superior to mathematics in the social structure of the discipline. For words are a mode of expression with greater open-endedness, more capacity for connecting various realms of argument and experience, and more capacity for reaching intellectual audiences (Neuman, 1991: 414).

Data Analysed

Words from official documents, meetings correspondence and submissions to H.P.R.A.C. will be looked at for emerging themes and patterns.

As a qualitative researcher, I proceed by extracting themes and organizing the data to present a coherent, consistent picture. It is evident that attempts have been made, through legislative changes, to reorganize health care delivery. In preparation for legislative enactment, the applications of power and the inevitable resistances become evident.

Agonism

Granted independence as a regulatory body, dental hygiene was enabled to contest the existing institution of dentistry and the practices surrounding the mouth. This liberation allowed for the complicated interplay involving dentistry and dental hygiene, the struggle and 'agonisms.' An agonism is a relationship which is, at the same time, reciprocal incitation and struggle, a permanent provocation rather than a face to face confrontation. It is rather like a wrestling match; a mental, emotional, and physical contest in which the opponents develop a strategy of mutual taunting (Dreyfus and Rabinow, 1983: 221-2). Various data serve to illustrate the agonisms.

Official documents include:

- the <u>Health Disciplines Act 1976</u>;
- the <u>Regulated Health Professions Act 1994</u>;
- the <u>Dental Hygiene Act 1991</u>;
- <u>Striking a New Balance</u>;
- proposed amendment to the Dental Hygiene Act;
- selections from Legislative committee meetings;
- summary of the Professional Relations Branch consultative process; and,
- submissions to the Health Professions Regulatory Advisory Council.

The Transitional Council for the College of Dental Hygienists was a significant factor in dental hygiene's attempts to initiate change in oral health delivery. The Transitional Council was appointed in 1992. Unlike other established regulatory councils such as dentistry, this particular Council was composed of an equal number of public and professional members, and was reflective of the residents of the province; ethnically, culturally, economically, and geographically. The six public members and six professional members all agreed that dentistry's rigid interpretation of the word 'order' was not in the public interest.

Don Page, a public appointee, assumed the role of coordinator of the Regulations Working Group. Thus, he played a key role in the attempts to amend the Dental Hygiene Act 1991.

Many meetings were held to resolve dentistry and dental hygiene's differences. Some were initiated by the College of Dental Hygienists and others by the Ministry of Health. Relevant correspondence was generated as a result of many meetings. Some of these meetings included:

- November 10, 1993 - Ministry of Health Professional Relations Branch;
- November 24, 1993 - College of Dental Hygienists (C.D.H.O.), Royal College of Dental Surgeons (R.C.D.S.O.), and Public Health Dentists;
- December 20, 1993 (a.m.) - Ministry of Health officials, C.D.H.O. with consultant Jane Fulton;
- December 20, 1993 (p.m.) - C.D.H.O. including Jane Fulton with the R.C.D.S.O.;
- April 14, 1994 - C.D.H.O., R.C.D.S.O., and Ministry of Health officials to explain the process for May 25, 1994, consultation session to prepare for proposed amendment;
- May 25, 1994 - Professional Relations Branch, Ministry of Health Consultation session;
- August 29, 1994 - Professional Relations Branch and C.D.H.O.;
- October 18, 1994 - Health Professions Regulatory Advisory Council, C.D.H.O.;
- December 22, 1994 - C.D.H.O. and R.C.D.S.O.

Key bureaucratic and other organizations are involved in the study. The Ministry of Health, Professional Relations Branch of the Ministry of Health, the Public Appointments Branch, C.D.H.O., R.C.D.S.O., O.D.A., O.D.H.A., Ontario Association of Orthodontists, Ontario Society of Paediatric Dentistry, the Ontario Society of Periodontists, the Ontario Society of Public Health Dentists, the SHOUT Clinic, and various consumer groups.

After proclamation, the C.D.H.O. held forums throughout the province to inform registrants about the legislation and the implications of the word 'order' in their working relations with dentists and the public. Also after proclamation, the Minister of Health, in an attempt to resolve the 'order' issue through the Ministerial process, directed the Public Relations Branch to hold a public meeting of the stakeholders. The C.D.H.O.'s proposed amendment (Appendix C) was used to initiate discussion at this open consultation session. This meeting was convened on May 25, 1994, by the Public Relations Branch. The regulatory bodies R.C.D.S.O. and C.D.H.O. were present. Also, the voluntary professional associations of dentistry (O.D.A.) and dental hygiene (O.D.H.A.) were present. Presentations were also made by individuals and the dental specialities of orthodontia, paedodontia, periodontia, and public health. Written submissions, letters and the P.R.B.'s subsequent summary of the issues are analyzed.

Political pressure was applied on June 8, 1994, when the Minister of Health was questioned by opposition M.P.P.s at the Legislative Standing Committee on Estimates about her process for dealing with the proposed Dental Hygiene Act amendment. Recognizing that the crowded Fall legislative agenda, with its constrained time frame and the pending provincial election could result in the death of the proposed amendment, the C.D.H.O. on September 16, 1994, reactivated its request for a referral by the Minister of Health to her Health Professions Regulatory Advisory

Council. The matter was referred and the Minister asked for a response from H.P.R.A.C. by April 30, 1995.

H.P.R.A.C. circulated questions with a February 28, 1995, deadline for submissions. In March 1995, H.P.R.A.C. invited participants to submit any new information or clarifications by April 18, 1995. It was anticipated that a favourable report would be submitted to the Minister, preparing the way for increased access to dental hygiene services and, thus, a change for consumers in their ability to access dental hygiene services. As this is being written, the Report has not yet been submitted to the Minister, nor is it expected to be submitted until late August or September 1995. The delay, apparently, is the result of time constraints and pressures of other referrals such as the Nurse Practitioner and Naturopathy. Another delay in the legislative process of amending the Act has been created by the election held June 8, 1995, when the New Democratic Party of Ontario was defeated by the Progressive Conservative party. It will take the bureaucrats some time to brief Jim Wilson, the recently appointed Health Minister, on the various relevant health issues, including the proposed Dental Hygiene Act amendment.

Researcher's Background and Participant Observation

This researcher's involvement is not one of an uninterested observer. My father and his father were dentists and my mother was a dental nurse who, after marriage, stayed home to raise the family. My socialization in the family provided me with an understanding and perspective of the institution and practice of dentistry. Also, practical experience has placed this researcher in a longstanding, participatory observation position.

> Participant observation involves the researcher being a participant during the data gathering process. Participant observation combines ways of data gathering such as ... document analysis with direct observation (Kirby and McKenna, 1989: 76).

In addition to practising dental hygiene for twenty-eight years with a number of dentists, one half day a week for eleven years I taught dental hygiene clinical skills. In 1980, when the R.C.D.S.O. introduced dental hygiene representation, after more than 30 years of regulating the profession, I was one of two dental hygiene official observers elected by my peers. I served in this non-voting position for twelve years. When the Transitional Council of the College of Dental Hygienists was appointed in November 1992, I was appointed by the government as a result of my regulatory experience. From November 1992 until December 1993, I served as Chair of the Transitional Council of the C.D.H.O. and after proclamation, as President of the College in 1994 and 1995.

Through many years of involvement with the regulatory system by dentistry and presently with the developing regulatory organization of dental hygiene, an understanding of the process and inside knowledge has been gained. As an insider, I am experiencing the "agonisms" as dental hygiene struggles to attain actual independence and self-regulation. This research project provided an excellent opportunity to complement practical experience with philosophical and sociological theories.

To provide options for both providers and consumers, attempts have been made to permit self-initiation for the controlled acts of scaling, root planing, and curetting surrounding tissue. All the members of the Transitional Council of C.D.H.O. encountered both official and unofficial bureaucracies, professional dominance with attendant differential access to powers and deficiencies of service to the public, while advocating for increased public access to dental hygiene services.

In addition to participating in the data collecting process, my academic background has provided a perspective from which to review, study and analyze the data. The themes of power/knowledge, professional dominance, technologies of bureaucracy and gender inequities emerge as attempts are made to change the social organization for the consumers of health care as well as the regulated providers.

The background to the study outlines differences in the previous regulatory system, such as the broad scope of practice for licensure of professionals, leading to cartel-like functioning, the lack of peer review of professionals, and the inability of the consumers to participate on regulatory bodies. With previous legislation, consumers did not influence policy decision which ultimately affected the public. The H.P.L. Review, established in 1982, studied regulatory bodies and methods of licensure through independent research, and held consultation with stakeholders to achieve proposals for new health legislation that would balance accountability of professionals and accessibility for consumers to choose their health care providers.

Dental hygiene and dentistry were two such stakeholders and some details are provided in Chapter 2. Chapter 3 introduces the theory and literature used to support the discussion of power/knowledge, discourse (speech and language), professional dominance, the medical treatment model, the technologies of bureaucracy, and gender. The discussion in Chapter 4 builds upon the theory and literature and centres around the themes of power/knowledge, professional dominance, the medical curative treatment model, technologies of bureaucracy, and gender.

Chapter 5 is the summary of findings. Here it is shown that there is a change in the social organization of the regulation of the providers. New, independently regulated professionals/ providers are enabled through the Regulated Health Professions Act to publicly resist established practices. At this time, it is not possible to provide evidence that enactment of the new legislation has changed the social organization of health care delivery in the community for consumers.

Research can be continued to determine if increased access and availability becomes a reality. The R.H.P.A. provides a wealth of research potential, thus, a section is devoted to some suggestions for future study. Limitations to the study are also included.

The institution and the practices surrounding the mouth have received little attention. Thus, this study should make an additional contribution to the sociological body of knowledge.

CHAPTER 3:
BACKGROUND TO STUDY

Health Professions Legislative Review

New health legislation was proclaimed in Ontario in December 1993. In preparation for this legislation, credentialling, licensing enforcement and regulation had been surveyed worldwide, to determine if the existing model of regulating professionals actually protected the public from harm or merely protected the economic status of the professionals. Prior to January 1994, medicine, dentistry, pharmacy, optometry, and nursing were granted the power of self-regulation through the Health Disciplines Act.

The Health Professions Legislation Review, established in November, 1982, was critical of the Health Disciplines Act, 1976, as licensed health professions, such as medicine, had a monopoly over the provision of services by other health personnel. The Review noted that there was disparity between what was licensed in theory and practiced in reality. For example, although work in the mouth was licensed to dentists, in practice scaling/cleaning was done by dental hygienists. The Review concluded that many activities provided in the health care field are not harmful. Thus, to prohibit caregivers from providing harmless services because "they are within the scope of a licensed profession maintains a useless fiction" (Schwartz, 1989: 14). Further, it is almost impossible to enforce an exclusive license to practice. The Review also concluded that the existing model of the H.D.A. perpetuated a hierarchical model and, as such, maintained unequal relationship between the "dominant" licensed professions, the registered professions, and the non-regulated professions. The hierarchical relationship produces tensions between professions and, therefore, inhibits cooperation and communication. The Review states:

> Licensure restricts evolution in the scope of practice of the unlicensed professions and inhibits the development of new professions. It inhibits innovation in how the various health professionals can be utilized; this makes it difficult for institutions like hospitals and community health centres to use combinations of health professionals that will provide the best service at the lowest cost (Schwartz, 1989: 14).

The Review decided upon a controlled or authorized acts concept. Every professional Act would contain a general scope of practice statement describing what the profession does, the method it uses, and its purpose. The H.P.L. Review stated that the scope of practice statement describes for the governing body the area of practice for which entry requirements and standards of practice are required. Consumers can identify the proper range of the professions' scopes of practice. Educators have a guide to design and update curricula. Thus, the scope of practice statement will assist educators in developing curricula that reflect the changing needs of society in the health care system.

The Health Professions Legislation Review worked towards "striking the proper balance between professional independence and public accountability." The Review was aware that a dismantling of the professional dominance needed to occur in the new health legislation if the public was going to have freedom to choose health care providers within a range of safe options. The new health legislation was intended to promote evolution in the roles played by individual professions and flexibility in the utilization of professionals so that health services would be delivered with maximum efficiency (Schwartz, 1989: 2).

The sole purpose of regulation, according to the Review (Schwartz, 1989: 3), is to protect the public interest, not to enhance any profession's economic power or to raise its status. The public is the intended beneficiary of regulation, not the members of the profession. The public should have the freedom to choose its health care services and it has the right to be protected from unqualified, incompetent and unfit health care providers.

Public representation on the professional regulatory Councils would be just under 50%. It was hoped that the increased public/consumer participation would encourage the elected professions on the Councils to govern according to what is best for the public, not what is best for the profession. Consumers of health care would have direct input into the regulatory system. Increased public representation provides an opportunity for increased cultural and ethnic diversity. Hopefully, the Councils would become more representative of the public of Ontario. Also, policy developed by Councils would focus on the public interest. The public interest expands with the Regulated Health Professions Act beyond "do no harm" and includes the matters of equity, access, accountability and affordability. Service to the individual would be provided according to their needs and professional standards (Friedson, 1970: 223-224).

The need for formal, periodic review of the quality of performance of professionals' work also was recognized by the Review. As this need was identified, it was incorporated into the R.H.P.A. The Quality Assurance programs will require professionals, by law, to participate in continuous learning. Hopefully, this assures that the majority of practitioners will stay competent and current as this is definitely in the public interest.

Also, an effective Patient Relations program is supposed to improve the public's perception of the profession. The public has placed trust in the health professional and this trust has been abused by some, for instance, by some members of the profession of medicine. Thus, the College of Physicians and Surgeons of Ontario has been severely criticized for ignoring the sexual abuse of patients by some physicians. To increase the awareness of professionals and public, every self-regulating College is required to develop a sexual abuse prevention plan. Hopefully, through this process, societal change will take place and the social structure of health delivery will no longer permit behaviours such as sexual abuse that were overlooked or excused in the past.

The Review established that self-regulation is a privilege, not a right, of an occupational group. In order to remove the hierarchical system, professional dominance is being dismantled. Outside evaluation of professionals and increased public input may be a means of establishing a balance. The new regulatory model is supposed to increase the autonomy of the health occupations which have been included in the Regulated Health Professions Act.

Dentistry is an example of one dominant profession that is not prepared to give up its dominance without a struggle. As Coburn noted in his research into the R.H.P.A.:

> Politically, the more established occupations (particularly dentistry) have tended ... to resist ... more state regulation of the professions through the new proposed system (Coburn, 1993: 136).

Also, dentistry views the increased public participation as a major "infiltration of public or state power into what was once purely professional organization" (Coburn, 1993: 129) and an interference in its regulatory process. Dentistry officially opposed self-regulation for dental hygienists during the Review. Through state authority of the H.D.A., dentistry obtained the political and legal position of professional dominance, protecting it from the encroachment by dental hygiene. The Royal College of Dental Surgeons had the power of statute to define and control the practice of dental hygiene and thus control the conditions of work of dental hygienists. It determined the qualifications to practice dental hygiene in addition to influencing the educational process for dental hygiene. "These professional privileges are legitimized through the use of professional dental ideology which rationalizes this extraordinary imbalance of power to be in the public interest" (Kazanjian, 1992: 18). Dentistry had a tradition of accommodating public health programs by varying the rules and making exceptions for dental hygienists in those programs. The sexual division of labour has served the interests of the dental profession in maintaining the status quo rather than improving the delivery system to meet the needs of the public (McIntyre). As might be expected, dentistry did not accept dental hygiene's autonomy and independence that was to be granted through legislation. Thus, a struggle emerges exposing opposing strategies, power relations, and, what Foucault calls an 'agonism':

The voluntary organization, the Ontario Dental Hygienists Association, became the official spokesperson for dental hygiene to the Review, strongly supporting dental hygiene as self-regulating. As early as 1970, in a Report to the Commission of the Healing Arts, they recommended that dental hygiene be self-regulated and:

> self-regulation would remove the conflict of interest that is present when the governing body is also the employer. This conflict arises when the regulatory body that controls scope of practice, education and licensure, is composed of employers that share the same scope of practice and control the day to day working conditions. When dental hygienists request a change or improvement that may not be agreeable to the dental profession a strong dental lobby may render the Council ineffective (O.D.H.A., 1983).

Despite opposition from organized dentistry dental hygienists were one of the occupations granted self-regulation:

> On March 12, 1987, the Minister announced that dental hygienists will have their own governing body ... Mr. Elston's decision reflected the fact that while dentists and dental hygienists work in close proximity, they are separate professions. Dental hygiene has evolved to the point where it is appropriate for hygienists to govern themselves independently of dentists (Schwartz, 1989: 8).

The Honourable Mr. Elston also noted that the employer-employee relationship between dentists and dental hygienists led to regulatory disagreements about supervision requirements. He stated that dental hygiene self-governance will increase effectiveness and allow for mechanisms and authority to address dental hygiene issues (Elston, 1987).

Once self-regulation was acknowledged by government, organized dentistry opposed dental hygienists having any licensed/controlled acts or power to assess teeth and gums. The Ontario Dental Association took a strong stand in an attempt to maintain dental monopoly over people's mouths.

> The notion that dental hygienists should undertake assessment and treatment of teeth and gums without the order of a dentist is both wrong and dangerous. It is completely inconceivable that any person with two years training in a community college can understand the pathology present in a patient's mouth prior to treatment, or, more importantly, the pathology which may exist in a patient's mouth after treatment. Since the procedures involved in "preventive measures" are invasive, invariably involve the letting of blood, they should only be undertaken on the order of a practitioner who understands both the procedure and the sequelae (O.D.A., 1986: 6).

The Royal College of Dental Surgeons, in its response of January 29, 1988, supported the O.D.A.:

> The relationship between dentists and dental hygienists is well established and not one which neither dentists or dental hygienists have yet determined should be changed ... In the College's view, the dentist is and should continue to be the "gatekeeper" of dental hygiene and it is therefore appropriate to ensure that the licensed acts of dental hygiene are performed "upon the order of a dentist legally qualified to make such an order" (R.C.D.S.O., 1988: 18).

The R.C.D.S.O. does address the social structure and, obliquely, the economic structure of dental services.

It is interesting for this writer to note that a section of the R.C.D.S.O. response to the Review stated that:

> the College is strongly of the view that dental hygiene should be treated in accordance with the same principles

> utilized for other professions of similar type (R.C.D.S.O., 1988: 18).

The profession of "similar type," not surprisingly, is nursing. It is interesting to note, and this thesis will address the issue of gender directly, that the professions that have an 'order' in their Acts are Dental Hygiene, Medical Laboratory Technologists, Nursing, Respiratory Therapists, and Radiologists - all predominantly female.

The R.C.D.S.O. response continues:

> The Review has indicated to the College (R.C.D.S.O.) that it is able to ensure that the independent practice of dental hygiene is controlled by regulations in the professions' specific legislation for both dentistry and dental hygiene. In the view of our legal counsel, the ability to limit the independence of the practice of dental hygiene through regulation having regard for licensed acts which clearly establish the right to practice independently is questionable... (R.C.D.S.O., 1988: 19).

It is the interpretation of this writer that the Review intended to legitimize the autonomy of dental hygiene and, thus, increase the access of consumers to oral health care through the new legislation.

Dentistry

> "Dentistry historically has emphasized the identification of disease and injury in order to determine the dental diagnosis and treatment through the use of medication and invasive methods (restorative therapy and surgery). In dentistry, dental health has been operationally defined as the mechanical elimination of disease, or the correction of the injury by the dentist, however temporary, fostering a dependent role for the client." (Darby, 1990)

Dentistry, like medicine, has a tradition of organized autonomy. Previous legislation, the Dentistry Act and the H.D.A., granted dentistry exclusive organizational power over the mouth. Dentistry maintained professional dominance and autonomy in its control through regulations and organization of the work of its personnel. Over the last hundred years, the normal range of dental services provided has remained fairly constant. Also, under the existing system of private practice, self-regulation and professional dominance, "the dental profession has achieved too little in Canada in the way of distributing its members to areas where they are needed and wanted" (Stamm, 1981: 72-73).

There are ten dental schools in Universities in Canada, two in Ontario. The Faculties of Dentistry at the University of Toronto and Western University graduated in 1991 a total of 133 dentists (Health Canada, 1993: 58). The number of active licensed dentists full-time and part-time in Canada in 1991 was 14,621 and in Ontario, 5,988. The population per active licensed dentist in Canada in 1991 was 1,934 and in Ontario it was 1,760. In 1991, there were 34 specialists certified in dental public health in Ontario, no change since 1989. In 1991, there were 128 specialists certified in periodontics, an increase of 5 since 1989 (Health Canada, 1993: 48.54). Most graduate, licensed dentists are male, and are in fee-for-service practices in urban areas. It is estimated that approximately 85% of Canadian dentists are in private practice (Stamm, 1981: 72).

Unlike medicine, dentistry has managed to avoid government interference in its private practice, financially, and organizationally. Unlike medicine, which is funded through government programs, dentistry has managed to avoid third party government payment plans. Most financial transactions with patients are direct payment, fee-for-service, or third party payment plans underwritten by private insurers. One out of every four dollars spent on dental care in private dental offices comes from non-government, third party dental coverage (Stamm, 1981: 72-73).

The dental profession's income is generated in private practice from individual patients who have sought treatment. More money is generated in a private practice by increasing the number of patients that are treated and increasing the number of services to each patient. (Dental hygienists add to dentistry's income as they can provide many services. Examinations, X-rays, scaling, polishing, root planing, etc., and are done by the hygienist while the dentist is performing other procedures, or merely "supervising.") The dentist usually charges according to the Ontario Dental Association fee guide which is the same fee that would be charged if the dentist performed the service. Dental hygienists generally are paid on a daily basis, excluding benefits. This amount seldom reflects the amount of the fees charged to the patient/client for the dental hygienist's procedures.

Croucher documents the fact that the dominant profession of dentistry and its curative medical model can, in fact, be an obstacle to good oral health. In Saskatchewan, dentists lobbied to have Government cease employing dental nurses who were very effectively providing dental treatment for school children (Croucher, 1988: 346-361). Croucher states that the College of Dental Surgeons of Saskatchewan stressed the parochial issue of the autonomy of the dentist. Dentistry referred to the greater need for supervision of subordinate personnel along with a preference for a service modelled on the existing private practice fee-for-service model (Bolaria, 1988: 311).

Directing and controlling the preventive and periodontal work of the subordinate occupation of dental hygiene was characteristic of the autonomy attached to the professional dominance of dentistry, which is predominantly male (Health Canada, 1991: 59). Dentistry chose to delegate oral domestic maintenance:

> ... specific job functions in health care have become associated with traits perceived to be male or female attributes, and the traditional diversion of labour between men and women in the family has been transferred to the health labour force ... (Kazanjian, 1992: 15).

The "mouthkeeping" procedures (i.e., oral domestic maintenance), are carried out by dental hygiene. These acts are essential for good oral health and well-being. Early education of children is important to impart health knowledge of the mouth, the gateway to the body, if general good health and well-being is to last a lifetime.

Dental Hygiene

> Dental hygiene, since its inception, has emphasized the prevention of oral disease and the role of the client in controlling factors which cause disease. Dental hygiene's commitment is to promoting human health, welfare and quality of life through knowledgeable dental hygiene services. It is dental hygiene that uniquely views the client as being actively involved in the process of care because it is ultimately the person who

> must use self-care to obtain and maintain oral health (Darby, 1990: 90).

The original design of the educational/training program for dental hygienists at the Faculty of Dentistry University of Toronto codified a patriarchal structure. Admission to dental hygiene was limited to women over the age of 18. The basic diploma program was established as two years, although most university courses were three years in length and graduates were awarded degrees. Two years were considered enough time to train a young woman for the delegated tasks of dental hygiene. In this time, she could acquire a sufficient knowledge base without having been ascribed undue status.

> It is alleged that female employees, psychologically, are quite content and happy to work under authority whereas the male is not so inclined. Secondly, it is contended that the male would be much more likely to operate beyond the scope of his legal authority or locate in areas independent of the supervision of a dentist thus creating problems in the enforcement of the Dentistry Acts ... lastly it seems to be generally agreed that the female is prettier than the male (Dunn, 1961: 19-23).

By statute, dentistry was given the legal monopoly over the mouth and who would work in it. The Royal College of Dental Surgeons granted dental hygienists a licence to practice duties within the practice of dentistry. Dentistry had the power to define and control the practice of dental hygiene and, thus, control the employment conditions of dental hygienists.

> Subject to the approval of the Lieutenant Governor in Council, the Council may make regulations, a) providing for the establishment, development, regulation and control of an ancillary body known as dental hygienists; b) regulating the conditions and prescribing the qualifications for admission to such body; c) prescribing the admission and annual fees payable by members of such

body; and, d) generally, for the defining, regulating and controlling of the practice of dental hygiene (Health Disciplines Act, 1976).

Licensure provides the profession with a legal monopoly over the performance of some strategic aspects of its work and effectively prevents free competition from other occupations (Freidson, 1970: 134). Licensure provided dentistry with a legal monopoly over its own work and professional dominance and authority over dental hygiene's work. Regulation 447 under the Health Disciplines Act set out in paragraph 50(1) what specified acts dental hygienists could perform in the practice of dentistry under the supervision or direction of a dentist in Ontario.

Dental hygienists were granted a license to practice giving the profession of dental hygiene the illusion of autonomy. However, printed on the back of the dental hygiene license, were listed 13 duties of a dental hygienist:

1. Preliminary examination of the oral cavity and surrounding structures including the taking of a case history, periodontal examination and recording of clinical findings.
2. Complete prophylaxis, including scaling, root planing, subgingival curettage and polishing of fillings.
3. Topical application of anti-cariogenic agents, and other materials designed to assist in the prevention of cavities.
4. Taking impressions for study models.
5. Maintenance of a patient's oral hygiene.
6. Placement and removal of rubber dam.
7. Application and removal of periodontal dressings.
8. Removal of sutures.
9. Placement and removal of arch wires previously fitted by a dentist.
10. Separating of teeth prior to banding by a dentist.
11. Cementation and removal of bands or brackets or both for orthodontic purposes that have been previously fitted by a dentist.
12. Application of topical anaesthetics.
13. Topical application of desensitizing agents.

Also on the back of the license was the statement, "the above duties must be performed in the same office suite as a dentist who is supervising the dental hygienist" (R.C.D.S.O. Licence, Item 129, 1993). In reality, the license was a right to work in a dentist's 'closed shop.' Under the H.D.A., dentistry defined dental hygiene's scope of practice as a list of duties. However, the fact it granted a license acknowledged an arena of dental hygiene practice and initiated the evolution of the profession of dental hygiene.

Through state authority of the H.D.A., dentistry obtained the political and legal position of professional dominance, protecting it from the encroachment by dental hygiene. Dentistry granted the license and determined the qualifications to practice dental hygiene in addition to influencing the educational process for dental hygiene.

> ... powers of professional self-regulation comprise not only professional autonomy but also the privilege to define the conditions of work of other personnel associated in that profession's division of labour. These professional privileges are legitimized through the use of professional dental ideology which rationalizes this extraordinary imbalance of power to be in the public interest (Kazanjian, 1992: 18).

Under the H.D.A., dental hygiene had no statutory authority to discipline its own members. Dental hygienists were restricted in dentists' practice settings due to the interpretation of supervision by the dentists' governing body (R.C.D.S.O.). A dentist had to be present in the same suite of offices in which the dental hygienist was working. This limited access to dental hygiene care by the public as it is financially impractical for institutions to hire both a dentist and a dental hygienist. One of the public members serving on the R.C.D.S.O. for six years said that

> the profession has done little to improve the dental care of the institutionalized. I firmly believe that the most important factor in correcting this situation would be a change in the attitude of some members of the profession towards the meaning of supervision (Monteith, 1984: 52).

The H.D.A. maintained the status quo and perpetuated the professional dominance and the medical treatment model of health.

The control of the educational curriculum was an effective social control which enforced the occupational hierarchy in dental practice. In the late 1970's, the dental hygiene program was moved from the University of Toronto to the Community Colleges because they were non-degree granting. Dental hygiene was no longer a direct entry program. Ontario Community Colleges offered a "ladder" approach to dental hygiene education, with the first year of training providing the requirements for dental assisting.

With self-governing autonomy, dental hygiene, itself, can evaluate the curriculum to ensure that it reflects the profession's scope of practice statement:

> The practice of Dental Hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services (<u>Dental Hygiene Act, 1991</u>),

and; it prepares the dental hygiene graduate to provide oral health care to a changing society. Undergraduate dental hygiene programs in Ontario are offered at thirteen institutions. The education and training takes place in a variety of communities throughout the province; Ottawa (2), Sudbury (2), C.F.B. Borden, North Bay, Thunder Bay, Oshawa, London, Toronto (2), Orillia, and Windsor. Courses are provided in French and English at Cambrian College in Sudbury. LaCité Collegiale in Ottawa provides dental hygiene in French only. The Community College system offers diverse occupational courses and dental hygiene students have direct contact with people from various socio-economic cultural and occupational groups. On the other hand, dentistry in Ontario is taught in English only in the urban areas of Toronto and London at the Faculties of Dentistry.

The dental hygiene process of care (assessment, planning, implementation, and evaluation) incorporates decision-making, problem-solving and critical thinking. Students are exposed to clinical experiences that are client-centred and comprehensive in nature. The Program emphasizes the prevention of oral disease and the role of the client in controlling factors which cause disease.

Now it is recognized that dental hygienists' formal training and preparation make them excellent candidates for independent practitioner roles (Kazanjian, 1992: 15). Although dental hygienists are trained to be skilled, knowledgeable, and competent to provide primary health care, they have played a powerless role in the professional dental organization of private practice. Even though they provide a major pivotal role in delivery of services, generally they have no direct involvement in the major decisions involving the practice. Although there is a fee code for oral hygiene instruction, non-treatment items of prevention are seldom paid for by third party insurance plans. Therefore, dentists generally do not direct those non-paid procedures to be implemented. In many cases, dentists control the scheduling of the dental hygiene procedures. Although an assessment by the dental hygienist may determine that the client requires, for instance, four hours of periodontal therapy and extensive oral health promotion, the dentist may not support the dental hygienist's recommendation. Frequently, the determination for care is based, not on a differential diagnosis, but on the patient's private dental insurance plan. Thus, further 'agonisms' may surface if the dental hygienist's ability to provide dental hygiene care as set out by the standards of practice of the governing body is hampered by third party payment determinations.

Dental hygienists are trained and educated to emphasize the prevention of oral disease and the participation of the client in their own health. Therefore, dental hygiene is consistent with the paradigm shift from the medical treatment model to the disease prevention/health promotion wellness model. Clients are encouraged to become actively involved in the health care process, not just through compliance or dependence on the dental hygienist but in the form of partnership or collaboration. Dental hygiene leaders recognize that the future health care providers will not be on a ladder of hierarchy rather there will be "a circle of providers with different skills and roles" (Woodall, 1992).

According to Health and Welfare Canada, there were 9,665 (Health Canada, 1993: 34) licensed dental hygienists in Canada in

1991, an increase of 833 since 1990. As of October 1991, 3,970 of the dental hygienists were in Ontario (Health Canada, 1991: 34). The population per licensed dental hygienist in Canada was 2,925 in 1991, a decrease of 240 since 1990, and in Ontario was 2,654, a decrease of only 43. In 1991, there were thirty-one schools in Canada that trained dental hygienists (Health and Welfare Canada, 1993: 34-37). There have been added in Ontario two French language programs, once at La Cité Collegiale in Ottawa, the other at Cambrian College in Sudbury. Also, several American dental hygiene schools train a number of Ontario residents who return to Ontario to practice after successfully completing the Ontario written and practical registration examination. The Faculty of Dentistry at the University of Toronto offers a post diploma program for dental hygienists. The Bachelor of Science in Dentistry (Dental Hygiene) Program requires University of Toronto entrance requirements, thus making it inaccessible to the majority of Ontario's Community College graduates whose entrance requirements do not meet those standards.

The Word 'Order'

Nursing and dental hygiene are two predominantly female health occupations which have the commonality of an overseeing dominant profession, medicine and dentistry. However, there are major differences. In the employment circumstances, nurses generally are employed and paid by non-profit, publicly funded institutions, not by physicians. Dental hygienists, on the other hand, are employed and paid generally by private practice dentists. Physicians and nurses have traditionally worked with orders and standing orders in institutions. Orders were foreign concepts for private practice dentists and dental hygienists. An effective lobby on the part of dentistry just prior to the passage of the R.H.P.A. and Dental Hygiene Bills resulted in the word 'order' in the Dental Hygiene Bill being required from a dentist so that hygienists could carry out the controlled/authorized acts:

> 4. In the course of engaging in the practice of dental hygiene, a member is authorized, subject to the terms, conditions, and limitations imposed on his or her certificate of registration, to perform the following:
>
> 1. Scaling teeth and root planing, including curetting surrounding tissue.
>
> 2. Orthodontic and restorative procedures.
>
> 5. (1) A member shall not perform a procedure under the authority of section 4 unless the procedure is **ordered** by a member of the Royal College of Dental Surgeons of Ontario.
>
> (Dental Hygiene Act, 1991)

Although the Dental Hygiene Act, 1991 sets out the dental hygiene scope of practice, which includes assessment and the authorized acts of scaling, root planing, including curetting, and restorative and orthodontic procedures, these authorized acts are limited by the legality that requires them to be 'ordered' by a dentist. The requirement of an 'order' restricts dental hygiene care as dental hygienists no longer self-initiate, i.e., start scaling without asking a dentist for permission. "It is wholly inappropriate to permit one profession to exercise such influence over another, particularly when there is evidence that the constraints are unnecessary in the public interest" (Wagner, 1994).

The legislation as it stands is antithetical to the original intent and does not reflect the realities of dental practice prior to proclamation of the R.H.P.A. Also, the R.H.P.A. was expected to result in increased options for consumers of health care services. The Dental Hygiene Act as it stands fails to do so.

Prior to proclamation of the R.H.P.A., dental hygienists self-initiated scaling, root planing including curetting unless there were contra-indications to the treatment. However, dentistry lobbied to have dental hygiene's authorized acts initiated by the word 'order' of a dentist because dentistry fought to maintain the 'gatekeeping' function.

> ... by becoming a gatekeeper to what is popularly valued the professional gains the additional sanction of being able to make taking his advice a prerequisite for obtaining a good or service valued independently of his service (Freidson, 1970: 117).

The word 'order' is dentistry's attempt to continue gatekeeping dental hygiene. The public members who made up half of the first Council of the College of Dental Hygienists were a driving force behind the proposed amendment to remove 'order' from the Dental Hygiene Act, 1991. The public members saw the inequity and injustice in the word 'order' requirement in the legislation. The 'order' requirement is interpreted by the C.D.H.O. as a barrier to choices and options in accessing oral health care. One public member stated that the R.C.D.S.O. policy was unacceptable because it appeared to be more concerned with protecting the economic interests of dentists in private practice and totally unconcerned with several public interest issues (Page, 1994: 1). The amendment will enable dental hygienists to develop working relationships outside of private practice dentistry.

> Choices for hygienists has a public benefit as well, since as hygienists are able to widen their practice arrangements, so more choices are made available to the public (Page, 1994: 4).

The following motion passed by a vote of eight to seven at the R.C.D.S.O. Council meeting and it maintained dentistry's "gatekeeping" function. Also, it sustained the professional dominance and dentistry's control of the social organization of oral health care delivery. It also perpetuated the medical treatment model of dentistry.

> That in respect of the proposed regulations on "Orders, Delegation and Assignment of Intra-Oral Acts," every new patient, or patients who have not been seen for at least one year, must be examined and assessed by the dentist before any order can be given (R.C.D.S.O., June 1993).

Order is an attempt of dentistry to maintain its power/ knowledge relation of the mouth.

D. Page, Coordinator of the Regulation Working Group for the Transitional Council for the College of Dental Hygienists, wrote to C. Jefferson, Chair of the Health Professions Regulatory Advisory Council, about the R.C.D.S.O. proposal regarding order:

> if implemented it would maintain control by dentists of the delivery of dental hygiene services to a degree that contravenes the intent of the new <u>R.H.P.A.</u>, i.e., to provide efficient, more affordable, and safe health options to the public of Ontario (Page, 1993).

<u>Public Interest</u>

Fortunately for those people favouring a greater public access interpretation as one of the objectives of the new legislation and the newly self-regulated bodies, some changes have occurred since the Review began in 1982. When Christie Jefferson, Chair of H.P.R.A.C., spoke to the R.C.D.S.O. Council in April 1993, she addressed the fact that the social and political climate in which self-regulation of health professionals is taking place has changed dramatically in the last five to ten years. Jefferson said that health professionals carrying out their statutory responsibilities to serve and protect the public interest, must consider equality, equity, access, and fair treatment. Regulated professionals must regulate in the public interest. Empowered consumers will settle for nothing less (Jefferson, 1993).

In preparing for the proclamation of the R.H.P.A. and the Dental Hygiene Act, 1991, the C.D.H.O. Council became aware of potential problems. Attempts were made to achieve mutual accommodation with the R.C.D.S.O. so that their regulations reflected the realities of the current dental hygiene practice in private dental practices and public health. However, the C.D.H.O. was unable to reach agreement with the R.C.D.S.O. So, on October 22, 1993, the C.D.H.O. wrote to the Minister of Health, Grier, advising her of the problem with 'order,' and asked the Minister to amend the Dental Hygiene Act, 1991 to resolve the situation "in a manner consistent with the public interest in the area of Dental Hygiene" (Page, 1993).

CHAPTER 4:
THEORY AND LITERATURE REVIEW

Many sociologists have written about power, professional dominance and gender. For the purpose of this study, three particular theorists have been chosen. Some ideas of Foucault, Freidson, and Smith are included as their work has helped this researcher develop the themes of power/knowledge, discourse, professional dominance, technologies of bureaucracy and gender.

An Introduction to Foucault

Michel Foucault is an extremely relevant theorist for today. He respects differences and acknowledges exclusion in the discourse. He analyzes modernity from various perspectives on modern discourse and institutions. He re-thinks power as diffused through multiple social sites as something that is exercised, not held in hierarchical structures. Thus, he provides a way to re-think our present institutions, organizations and practices.

As he examines and discusses new disciplines of social regulation, he breaks through disciplinary boundaries, rigid definitions, and categorizations. His work is of an interdisciplinary character, for instance the fine meshes of medicine, philosophy and sociology, thread through a common human web. His approach "teases" the reader into looking at things in new ways, and the opaqueness in his writing encourages further questioning and thinking about the various areas in today's society. For instance, power, as embodied in the law in statute, is written in negatives consisting of taboos; 'thou shall not.' Generally, power relations are considered to be clearly visible in hierarchical structures. Foucault's thought differs from this generally accepted concept. His approach is anti-structuralist (Foucault, 1980: 114).

Human beings are not autonomous subjects defined by some intrinsic nature, but subjects only insofar as they are shaped and molded as subjects by the events that comprise personal histories. Foucault focuses on power and his objective is to create a history of the three different ways that human beings are made subjects. First, the scientific mode of inquiry is an objectification and turns human beings into subjects. Second is the objectification of the object whereby the subject is either divided inside her or himself or divided from others, for example, the sick and the healthy. In medical practice, people tend to define themselves as objects, i.e., a medical problem. Third, the way a human turns her or himself into a subject.

The perception of self-changes through the various ages. Who am I? in medieval is "I believe;" in Cartesian, "I think;" in Romantic, "I feel;" in Existential, "I choose;" in Freudian, "I dream." When looked at this way, it becomes evident that the self is a position in language.

The point of understanding power is to understand how it shapes humans and the primary way power shapes humans is to make them subjects of a certain sort. Once it is understood how persons become subjugated, then it can be understood how their actions are constrained in many areas of life. It becomes evident that humans are not coerced by externality rather we are governed by internalized norms of our own making. We are, ourselves, products of our discourses, practices and history.

For Foucault, the individual is not a pregiven entity. Rather, the individual is the product of a relation of power exercised over our bodies, multiplicities, movements, desires, and forces. Truth is a product of power, and a person is a product of power. What each of us is, is what our activities and history have made us.

> The individual is an effect of power, and at the same time ... it is the element of its articulation. The individual which power has constituted is at the same time its vehicle (Foucault, 1980: 98).

Modern power, a relational power, is exercised from innumerable points. It is highly indeterminate in character, and is never something acquired, seized or shared. Power is an environment in which practices are enabled and inhibited. Power is not something that can be possessed nor is it unidirectional. Power is not a directed force or a set of static regulations or conventions or a persisting institution. Where there is power, there is resistance because the existence of power relations depends on the many points of resistance which play the role of adversary, target, and/or support. Therefore, resistance cannot be external to power. Foucault observes a close connection between resistance and power. "These points of resistance are present everywhere in the power network" (Foucault, 1990: 95). Resistances do not derive from a few diverse principles. Resistances in the relations of power are distributed irregularly:

> ... the points, knots, or focuses of resistance are spread over time and space at varying densities, at times immobilizing groups or individuals in a definitive way, inflaming certain points of the body, certain moments in life, certain types of behaviour (Foucault, 1990: 96).

Often the points of resistance are mobile and transitory, producing ruptures in a society and regroupings. Resistance arises at points where power relations are very rigid and intense such as those surrounding the mouth and oral cavity. Now resistance is taking the form of opposing discourses which may produce new knowledge and so constitute new powers. Thus, resistance is an important variable for initiating changes in society.

> Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities (Foucault, 1990b: 96).

To analyze power relations and to grasp what totalities do exist, one of the rationalities or practices Foucault looks at is health politics. One aspect of health politics is the history of the political and economic materialities of urban space, mass population, and the close knit family and bodies of individuals. Foucault, in <u>The Birth of the Clinic</u> (1975), gives concrete demonstration of how space is culturally constructed. The production of space as rationalized configurations is a political and economic phenomenon. There can be no politics of space independent of social relations. Space is a web of social power. Thus, reorganization of space is always a reorganization of the expression of social power. The clinic encompasses clinical medicine and the teaching hospital and the gradually developing totalizing practices of medicine.

The hospital, medical practice and the doctor are evidences of cultural construction. With the birth of the clinic, there is the: development of a medical market in form of private clients; the extension of a network of personnel providing medical services; the growth of individual and family demand for health care; the emergence of clinical medicine centred in individual examination, diagnosis and therapy; the explicitly moral, scientific and secretly economic progressive emplacement of a great medical edifice; the concurrent organization of a politics of health; and, consideration of disease as a political and economic problem. Health and sickness, as characteristics of a group, a population, are problematized in the 18th century through the initiatives of multiple social instances and the State plays various roles in connection with these relations.

Foucault looks at three major characteristics of the 18th century health politics: the family, the doctor and dehospitalization. As rules served to codify relations between children and adults, the family became an organizing environment for the child. The family was the localized teaching apparatus, the means to assure health of the child and a constant agent of medicalization. The result was a multiplicity of power relations, the family, the children, the medical corp., authoritarian interventions, institutionalization, and protection of the private doctor-patient relations. The privilege of hygiene and the function of medicine was an instance of social control which required control of urban space. The city became a medicalization object. Medicine, as a general technique of health, assumes an important role in the administrative system and the machinery of power. The doctor took on social power. Medico-administrative knowledge developed and a political medical hold was established on the population. The doctor became the great advisor and expert on observing, correcting and improving the social body.

A domestic organizational form of hospitalization had economic advantages as costs to society are less if people are fed and cared for at home. The family provided constant and adjustable care. The medical corps went to the family at home providing free or inexpensive treatment. Reform of medical and surgical studies in 1772 and 1784 required doctors to practice in boroughs and small towns before being admitted to certain large cities. There were efforts to elaborate a complex system of functions in which the hospital came to have a specialized role relative to the family. A network of medical personnel developed and also administrative control of the population. This change in function required spatial adaptation. The hospital space became organized for treatment and the hierarchial prerogatives of doctors were established. The system of observation, notation, and record taking made it possible to fix the knowledge of different cases. The hospital became a place for the accumulation and development of scientific, medical knowledge as doctors were trained for private practice. This summary of Foucault's disease politics illustrates how he analyzes power relations.

Foucault's critique appreciates the heterogeneity, complexity and discontinuity of power relations. Perhaps one of the reasons some feminists find Foucault's work appealing is the qualitative nature of his research and his persistent questioning. He carries out a critical analysis and he is logically consistent as he explores generally accepted "knowledges." Yet, it is evident that an underlying question is: How did humans get to be these objects? In the individualizing discourses that have become factual scientific knowledge, such as medical practice, the subject has become object. If the human being is merely a quantifiable, calculatable object of study, what happens to human dignity?

Foucault has taken "rationalities" and institutions and examined how they have inscribed themselves in practices or systems of practices.

Foucault's discourse goes beyond structures and institutions. He attempts to grasp the specificity and discontinuity of discourses. In the transition from one era to another, there is discontinuity as things become described, expressed, characterized, and classified in different ways. Foucault thinks that the task, today, is not so much to discover what we are; rather it is to refuse what we are (Dreyfus and Rabinow, 1983: 216). To do this, it is necessary to critically analyze the world and practice in the here and now.

Power, Knowledge & Discourse

Foucault recognizes that all work, like social life itself, is a collective. Power relations are rooted in the system of social networks, rather like the capillaries forming a total network in the body or the fine meshes of a living web. Foucault explores the interconnectedness of power and raises interesting questions. How are such relations of power rationalized? How is it that various forms of rationality became enmeshed and accepted as "the truth" throughout society?

Foucault's approach opens up the possibility for studying the micro-practices surrounding the oral cavity. This research examines and analyzes the institution and practice of dentistry, and the emergence of dental hygiene practice. This ordinarily mundane and academically unexplored area of the oral cavity provides an opportunity to examine multiple processes. These various processes create the conditions for the possibility of reorganization of oral health care delivery. As networks of professions, consumers, bureaucrats, and politicians oscillate between the curative, medical treatment model and the preventive wellness model of health, new power/knowledge of oral health hopefully will emerge.

Foucault states that his main concern has been with change, thus, change should be examined more closely. Different kinds of changes take place in discourse and it is best to respect such differences and even try to group them in their specificity (Foucault, 1973: xii). Various changes contributed to the discourse established surrounding the teeth and mouth in the 1800's. By 1878, factors such as demographic change and the development of school dental service increased the market for dental work. Dentistry is not the climax of technological advances, new discoveries, or the actions of great men of integrity. Rather, dentistry has attained its position today by political struggles for power and control. As a consequence of these struggles, Government granted dentistry the legal right to be the custodians of the oral cavity and the controllers of the application of the knowledge of the mouth. As dental practice evolved, the mundane procedures of cleaning the mouth were assigned to dentistry's agents, dental hygienists. Thus, the discourse in the 1990's is the result of collective occupational control strategies.

> The mouth and the teeth are not the static phenomena that dentistry has increasingly come to understand; they are variable concepts which are produced by dental perception which in turn is structured by its practices (Nettleton, 1992: 7).

The agonisms, resistances, and strategies inherent in power relations are evident as the 'tug of war' continues over the provision of preventive oral health services. Dental hygiene is struggling to break away from the constraints and submission that dentistry traditionally has imposed. The techniques of prevention are not merely associated with the possibility of achieving a society with health oral cavities. Rather, they have and will continue to produce a whole domain of knowledge. In the oscillation of the networks, there is a constant generation of power/knowledge.

At the very heart of the power relationship is agonism. This agonism is a relationship which is both reciprocal incitation and struggle. It is more of a permanent provocation than a face to face confrontation which paralyzes both sides (Dreyfus and Rabinow, 1983: 221-222). Although power is a shifting, changing set of relations, these relations can be frozen in abstraction. It is rather like taking a photograph of a single moment or event in an ongoing activity. This moment provides a starting point, an event which then can be analyzed. Foucault uses eventalization as a procedure of analysis. "Eventalization means rediscovering the connections encounters, supports, blockages, play of forces, strategies ..." (Burchell, Gordon and Miller, 1991: 76). Pre-proclamation and post-proclamation of the R.H.P.A. is an event where support, blockages, play of forces and strategies are evident in the vested interests of various bureaucracies, dentistry, dental hygiene, politicians, consumers and individual vested interests.

> ... every power regime, creates, moulds, and sustains a distinctive set of cultural practices including those oriented to the production of truth (Fraser, 1981: 285)

Many of these practices become enmeshed in the discourse. Part of this discourse is legislation and its attached regulations. Legislation impacts greatly on the social organization of various practices. The forms of resistance against different forms of power is a sort of chemical catalyst which brings to light power relations. As the Acts and their regulations are applied, forms of resistance are evident. For instance, the plurality of resistance and power relations became evident as the C.D.H.O. attempted to obtain an amendment to the Dental Hygiene Act, 1991. Until now, as previously stated, dentistry exercised an uncontrolled power over the public's oral cavity. The two elements now at 'tug of war' over preventive services are dentistry and dental hygiene. Previously, dental hygiene was merely the other:

> ... a power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that "the other" (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results and possible inventions may open up (Foucault, 1982: 789).

The dominant profession of dentistry has traditionally held clearly visible power in the hierarchical structures as it supervised and directed dental hygiene. With independent regulation, dental hygiene is faced with a whole field of responses and reactions.

Professional Dominance

Eliot Freidson has written extensively on professional dominance. In his forward, he states that there is a lack of public confidence in the public forum of health care. The present system has not accomplished its mission to heal the sick. Public confidence is failing because people are not healthier despite increased money and human resources in the system.

> Health services are organized around professional authority, and their basic structure is constituted by the dominance of a single profession over a variety of

> other, subordinate occupations. ... professional dominance is the analytical key to the present inadequacy of the health services (Freidson, 1970: xi).

In the field of health, dentistry and medicine are dominant professions (Freidson, 1970: 136). These professions are autonomous, i.e., self-directing. They control the content and terms of their own work. They are highly visible to the public, and are the gatekeeper, the primary access by the public to "expertise" about health. Their autonomy has been obtained from a legal or political position granted by government and reinforced by the Courts, thus protecting them from encroachment by other occupations (Freidson, 1970: 134). Dominant professions reflect the existence of a hierarchy of institutionalized expertise. Their structural position within the health care system has established the working relationships among the other health care occupations. Due to authority of expertise, the dominant profession directs and evaluates the work of others without, in turn, being subject to formal direction and evaluation from them (Freidson, 1970: 136). Patients or clients receiving treatment from the dominant profession have limited possibilities in their response to the "professional experts'" advice.

Freidson's theory of professional dominance is reiterated by M. Dent recently: Freidson's professional dominance has multi-faceted components. These are: i) autonomy over work; ii) control over the work of others in one's domain; iii) cultural beliefs and deference; and, iv) institutional power. The profession's dominance is seen as being institutionally rooted (Dent, 1993).

Professional dominance, according to Freidson, is based on the assumption that the professional has some sort of special knowledge and altruistic attitude which places them above other health occupations. The lay person has been conditioned to accept the opinion of the professional expert. The ideological foundation of health services is based on the assumption that those in the dominant professions are experts with special, unique knowledge and a code of ethics implying an altruistic attitude.

The profession is seen as a collection of individuals trained in a particular way, possessing specialized skill and knowledge and professing to adhere to a code of ethics. The profession, due to its esoteric knowledge and humanitarian intent, is thought to be able to decide what is good for the layman. However, there is no necessary positive correspondence between superior credentials and client care (Benoit, 1994: 306). In fact, the profession is only an occupation organized in a particular way with stable relations to other occupations and standing in a particular relationship to its clientele (Freidson, 1970: 58). The occupation is organized in a hierarchial relationship to other occupations. The dominant profession controls its work environment, the patients, and the personnel in its protected setting.

Those professions which have achieved professional dominance are organized so that they usually work in their own office which is rented and furnished by their own capital. They are usually insulated from colleagues who might peer review. In this isolation, they may not be aware of their inadequacies such as poor records, over-prescribing, or shortcut techniques. For instance, patients may pressure a dentist to prescribe some medication that is not necessary but the professional, in absence of peer review, does prescribe in order to please and retain the patient. The social structure of health care in this environment is a medical curative treatment model.

Medical Curative Treatment Model

MacDonald in Primary Health Care (1993: 30) states that the western medical model of health is an engineering model. It focuses on the individual body as a machine and the doctor as the medical scientist engineer, fixing and replacing. This engineering model of health is reactive to disease, treatment focused, not proactive for prevention of disease and promotion of wellness. It encourages a passive, non-participatory role for the lay person and an active decision making role for the health professional. This model removes the patient or the community from any situation of control in the encounter with the medical profession. It is curative and treatment focused and usually urban biased.

> One other characteristic of the western medical model is the masculine domination of the health profession. Specialized engineering, and so medical engineering, is generally considered to be a male domain (MacDonald, 1993: 40).

Bolaria, who quotes Renauds in "Sociology, Medicine and Health," describes and criticizes the engineering approach:

> ... the essentially curative orientation of current medical technologies toward specific illness rather than the sick person as a whole, and the belief that people can be made healthy be means of technological fixes, i.e., the engineering approach (Bolaria, 1988: 2).

The medical model is curative in function and attached to professional dominance. Freidson, as stated previously, views professional dominance as the analytical key to the inadequacy of the system to heal the sick. There are world wide attempts to implement a new paradigm which emphasizes equity, equality, accessibility, and greater participation of clients, and more autonomy of subordinate health occupations.

The World Health Organization has encouraged equity at international and local levels. Its efforts led the Alma Ata Declaration of 1978, emphasizing primary health care as the rational and practical approach to health care delivery.

Primary health care is defined in the Declaration of Alma Ata XI and represents an international alternative paradigm of health care to the medical model, or engineering approach.

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation at a cost that the community and country can afford in the spirit of self-reliance and self-determination (MacDonald, 1993: 59).

There are several aspects to primary health care, one of which is active involvement of the community, as it participates in health. Another aspect is intersectoral collaboration as other "sectors or disciplines" collaborate and have an important role to play in the establishment of good health. Also, equity is essential as people are involved in their own decision-making (MacDonald, 1993: 40).

Dominant professions and the medical treatment model have become an obstacle to good health as often the dominant profession, as gatekeeper, controls access of clients to alternative health services. Also, the dominant profession is financially dependent on the client's reliance on the professional's cure and treatment. Thus, the client's participation in his/her own health is seldom encouraged. Croucher documents the fact that the dominant profession of dentistry can, in fact, be an obstacle to good oral health. In Saskatchewan, dentists lobbied to have Government cease employing dental nurses who were very effectively providing dental treatment for school children (Croucher, 1988: 346-361). Croucher states that the College of Dental Surgeons of Saskatchewan stressed the parochial issue of the autonomy of the dentist. Dentistry referred to the greater need for supervision of subordinate personnel, along with a preference for a service modelled on the existing private practice, fee-for-service model (Croucher, 1988: 311).

One of the greatest dangers of the curative medical treatment model is its narrow focus on "the isolated physical state of individual clients and, consequently, virtual neglect of other, non-medical factors affecting health outcomes" (Benoit, 1994: 306).

Diem (1985) researched the Ontario Minister of Health's Spring Policy Conference in 1983. She documents one Health Minister's attempt to shift the health care paradigm from the predominance of curative and treatment to prevention. It became evident when this was not achieved that the doctrine of Ministerial responsibility is meaningless. Legislative control or Ministerial power is almost impossible over the health bureaucracy which is a fragmented structure with separate fiefdoms.

Technologies of Bureaucracy

Bureaucracy is an instrument of human reason, used for social control. It is a system of organization and communication which has similar effects as technology on human interaction, as does technology (Grant, 1986). Yet, reason implies humanity. In the technical domain of our society, reason and the intellect become necessarily operational and instrumental. We have seen an endless progression in reason from the single individual machine functioning rationally to a group of rational machines and then to a corresponding ordering of society, as people are turned into rational machines.

Weber's Theory of Bureaucracy as Rationalization

One of the strongest social theories is the theory of rationalization. Rationalization, the master concept of Max Weber, refers to a variety of related processes by which every aspect of human action becomes subject to calculation, measurement and control. These related processes involve the spread of bureaucracy, state control, and administration. Rationalization implies that the individual is separated from the community as he/she becomes subordinate to government surveillance and bureaucratic regulation.

Weber demonstrated that virtually all spheres of Western culture and social organization had undergone rationalization.

Rationalization was based on the assumption that both things and humans behave in a predictable way. Bureaucracy is an appearance of formal and technical rationality of the powerful rationalization process that resulted from the growth of capitalism. Also, professionalism encourages workers to conform to the bureaucratic and capitalistic values of their organization.

> ... potentially dichotomous norms and ethics of professionalism versus bureaucracy become one in the bureaucratized professionalism encouraged by prevailing socio-economic arrangements (Nelsen, 1991: 152).

An effective bureaucracy has a system of rational rules. It is a form of administration, distinctively characterized by precision, clarity, continuity, hierarchy, clearly defined regulations, documentary records, discretion, uniformity, separation of public office from private ownership, and the salaried employment of full-time, professional experts with career-long tenure. Weber believed that the fully developed bureaucratic mechanism had technical superiority over other forms. This is not necessarily true. When England had the most advanced capitalist economy in Europe, it also had the least bureaucratized and rational judicial system. Ancient Rome, the cradle of 'rational law,' failed to develop as it might because bureaucracy strangled its potential for industrial capitalism.

Porter writes in The Vertical Mosaic:

> Rational-legal legitimacy means that obedience depends upon the belief in the legality of orders. Power is exercised within a system of juridicial norms and obedience ... 'Rational' is linked to 'legal' because systems of law leading to constitutional power have emerged with the rationalizing of the world through modern science ... (Porter, 1965: 228).

The bureaucratic system does not rely on traditional moral commitment to its directives. It is a normative system. The school system in which professionals are trained is a significant part of the process of socialization to the bureaucratic routine.

> ... school socializes prospective professionals to separate self from work, and thereby to subdue overly emotional and subjective responses to standardized authority relations governed by a specialized administrative hierarchy. The result is students socialized to a profession which becomes synonymous with bureaucratized careers - careers in which, as impersonally-detached officials, they attempt to maintain an 'efficient' social distance from clients by the 'neutral' application of explicit rules and regulations (a system of standards) (Nelsen, 1991: 206).

Knowledge and skill of the bureaucratic instrument serves the values and priorities of the persons who control it. Bureaucrats become upset when a person meddles with their "air craft carrier" and "has never learned the institutional restrictions on governing" (Rae, 1993). The fully developed bureaucratic mechanism compares with other organizations exactly as does the machine with the non-mechanical modes of production (Weber, 1960: 164).

Weber was apprehensive of the increasing bureaucratization of modern society. "The immense concentration of power in fewer and fewer hands was bound to endanger liberal democratic institutions and to diminish individual freedoms" (Zeitlin, 1990: 185). Absolute efficiency leads to decisions made by executives and committee chairs and bureaucrats. Organizations exhibit the characteristics of today's social technological forces. They represent the consciousness of modern humans. These organizations and their leaders become powerful and decisive. Their presidents, executives, managers, and committee chairs are adept at, and enjoy, organization. They go about their conscious planning, and management of people. These groups speak on behalf of individual members to government, society and other organizations. They intervene and involve themselves in every aspect of the individual order with the resultant reduction in freedom of individual choice, action, and responsibility.

The bureaucracy is a power instrument for those who occupy its command posts. It facilitates the domination and control of large numbers of people. The individual bureaucrat is attached to his specialized activity and is only a small cog in the total operation. His entire mind and body have been trained for obedience and those who rule such organizations expect compliance as a matter of course (Zeitlin, 1990: 184).

A characteristic of these rational technological forms is the assumption that different values and cultures can be expressed in standardized forms. It is assumed that values, cultures or beliefs are malleable and autonomous enough to be translated into different forms without significant distortion of the values of culture or belief (Espeland, 1993: 314). Espeland, in the same work, quotes Roger Chartier:

> State perceptions of social phenomena are never neutral. They engender social, educational, or political strategies and practices that tend to impose one authority at the expense of others that are discredited, to lend legitimacy to a project or reform, or to justify an individual's choices and behaviour. A study of representation thus sees them as always captive within a context of rivalries and competition the stakes of which are couched in terms of power and domination. Rival representations are just as important as economic

> struggles for understanding the mechanisms by means of which a group imposes (or attempts to impose) its conception of the social world, its values and its dominion (Espeland, 1993: 315).

Bureaucracies produce socially constructed, organized language. This language or textual reality constitutes objectified knowledge. However, the experience of the individual within the textual reality are merely constructs of the persons controlling the construction. Thus, individual experience of the subjects is lost in the discourse.

> When I speak here of governing or ruling ... it includes what the business world calls management, it includes the professions, it includes government and the activities of those who are selecting, training, and indoctrinating those who will be its governors ... These are the institutions through which we are ruled and through which we ... participate in ruling (Smith, 1990: 14).

Gender and Relations of Ruling Within Bureaucracy

Professionalization is a rationalization. It is a relation of ruling based upon occupational authority. The production of a body of knowledge becomes increasingly important in the cultural dynamics of excluding certain groups. "Professions live with ideologies of their own creation" (Larson, 1977: xiii) and they tend to protect their élite group. Johnson states that, in all differentiated societies, the emanation of specialized occupational skills, whether productive of goods or services, creates relationships of social and economic dependence and social distance (Johnson, 1972: 41):

> ... the professional corporations are ... bureaucratic mechanisms with the function of enforcing monopolistic practices. Among the sociologists, Weber did not distinguish radically between the consequences of professionalization and bureaucratization and

> specifically linked the process of bureaucratization with the development of specialized professional education. [Weber] saw both processes as expressions of the increasing rationalization of Western civilization (Johnson, 1972: 14).

The transformation of healing from a female dominated neighbourly healing role to a male dominated, commodity-oriented medical service was systematic and deadly, according to Gross:

> English physicians campaigned through parliament and the courts to remove female healers from practice, asking for laws that would impose fines and imprisonment against women who dared to compete with physicians. The Church, and the State and the medical profession combined forces to hold witch trials to root out the women healers ... Women healers did not really have a chance - the situation was rigged against them. They were judged to be witches if they presumed to treat people without having studied medicine, yet they were not permitted to study in the only curriculum recognized as 'scientific' - the male dominated universities of the time (Gross, 1984: 60).

The profession of medicine has effectively tightened social control and values in the Western world. This is evident in the dominant professions' proliferating power throughout society. This expanding power is supported by government and political administration and societal élite. It is not surprising that medicine and other dominant professions such as dentistry are determined to maintain a position they fought to attain.

Dorothy Smith is a sociologist who explores forms of organization and their social construction and dominance. Smith identifies ruling as a complex of organized practices which include "professional organizations, educational institutions, and discourses in texts that interpenetrate the multiple sites of power" (Smith, 1987: 3). The characteristics of ruling are objectified and impersonal. The relations of ruling are governed by organizational logics, exactness, and criticalness. Particularly as women, "we are ruled by forms of organizations vested in and mediated by texts and documents, and constituted externally to particular individuals and their personal and familial relationships" (Smith, 1987: 3). Further she states that the making and dissemination of the forms of thought that we use to think about ourselves and our society are part of the relations of ruling. They originate in positions of power, which are usually exclusively occupied by men. Women's experience has not been included in forms of thought and in comprising the dominant discourse. Rather, concerns and interests informing "our" culture are "those of men in positions of dominance whose perspectives are built on the silence of women" (Smith, 1987: 19-20). Smith says once the characteristics are listed as they are in the case of professions; autonomy, educational requirements, and a code of ethics, etc., an organization of power is established. This textual reality becomes the "essential feature of the relations and apparatus of ruling" (Smith, 1987: 83).

Dentistry is an example of a dominant profession. The dominant professions maintain their special position by codifying their knowledge. This depersonalized objectified knowledge implies a superiority on the basis of cognitive "science." This codified knowledge impacts on the social organization of dental care delivery as dentists consider themselves the experts on the mouth. Dentistry has controlled the social organization of oral health care delivery. Working within the established private practices of dentistry, dental hygiene is an example of a social relation which has been organized into a certain determinate form (Smith, 1987: 78); a form in which dental hygiene was not asked for design contributions.

Ferguson also writes of women and the bureaucracy:

> [Women] who resist organizational oppression do so from within the very structure that creates that oppression. Embedded within bureaucratic discourse and institutions, resistance is carried out in bureaucratic terms by people whose subjectivity has been shaped and distorted by the requirements of technical society (Ferguson, 1984: 16, 17).

In earlier discussion of Foucault's thought, it was explained that power is an exercise, an activity, not an assumed or acquired position in a hierarchy. Power is not a substance nor a mysterious property whose origin must be delved into. Power is only a certain type of relation between individuals (Foucault, 1990a: 83). Every human relation is, to some degree, a power relation. The exercise of power consists of guiding the possibilities of conduct and exercising the possible outcomes. Viewed this way, power is not a confrontation between adversaries, rather, it is a question of government in its broadest term. However, it is necessary to have resistance to have power relations. Resistance is an inherent part of power relations. Without resistance, there is only obedience. Power relations are obliged to change with the resistances. Thus, modern power is productive as resistance challenges society's rules, opening up the possibility for change. The actual way that power is exercised is from innumerable points in the interplay of noneqalitarian and mobile relations. Power is like an environment in which practices such as dentistry and dental hygiene are enabled and inhibited: practices which, by being conducted, contribute to power (Prado, 1992: 142). Power is dynamic, changing and of many kinds. It is a way of action.

> As for all relations among men, many factors determine power. Yet, rationalization is also constantly working away at it. There are specific forms to such rationalization ... The government of men by men - whether they form small or large groups, whether it is power exerted by men over women, ... or by one class over another, or by a bureaucracy over a population - involves a certain type of rationality (Foucault, 1990a: 84).

Modern power is coextensive with the social body. The meshes of its network circulate continuously through the micropractices which comprise every day life in modern society (Foucault, 1980: 142). This collective life of power relations is embedded in discourse in the speech and language of institutions. The <u>Regulated Health Professions Act, 1994</u> embodies multi-health occupations with their plurality of relationships. This is bound to occur as 24 health professions are brought together under one piece of legislation.

The power relations which connected regulated professionals to each other and to their clients are worked out within the social context of the workplace and educational bureaucracies (Nelsen, 1991: 151). As Foucault shows, power relations create knowledge. However, power is only power when addressing individuals who are free to act in one way or another. It presupposes people's capacity as agents, it acts upon and through an open set of practical and ethical possibilities. Hence, power is everywhere as every human relation is, to some degree, a power relation. Power in a society is never a fixed and closed regime for humans move in a world of perpetual strategic relations. The new health legislation has the potential to enable and liberate previously subordinate health professions such as dental hygiene. The discussion in the next chapter expands on the themes and patterns of power/knowledge, discourse, professional dominance, the medical curative model, technologies of bureaucracy and gender.

CHAPTER 5:
DISCUSSION

The review of theory and literature provides a perspective with which to view the social context of some aspects of health delivery before and after the R.H.P.A. Each of the following sections provides a window through which to gaze at the R.H.P.A. and health care delivery. Using dental hygiene and dentistry as examples, one can observe and analyze forms of power relationships that impact on the social organization of health care delivery.

Discourse (Speech and Language)

It is this author's belief that Foucault's use of discourse contains a certain ambiguity to provoke the reader to thought. For the purpose of this thesis, discourse will mean the domain of speech and language.

Examining portions of the textual content of the Review, the R.H.P.A., the Dentistry Act and the Dental Hygiene Act reveals the discourse regime of the practice of dentistry and the social organization of oral health care delivery. It becomes evident, to this writer, that dentistry is imprinted with history. Dental hygiene, too, is a discursive practice that has its own history. The R.H.P.A. is seen as a point of emergence by this researcher.

> Emergent forms are transitory, no one person, or decision, or battle, or law, is responsible for emergence; it is, says Foucault, a momentary thing ... To study emergence, we need to explore an eternal play of dominations, of subjugations and struggles. Events take place within resistances ... (Nettleton, 1992: 124)

The R.H.P.A. is the result of the Health Professions Legislative Review. The Minister of Health established the Review in November 1982. The creation of the Review was the result of a number of resistances. Consumers, providers and government recognized the need for a change in the way health professionals were regulated:

> The public sought a more open, responsive and accountable regulatory system, especially in relation to complaint investigation and discipline processes. Many unregulated health care groups sought to be regulated. Groups regulated under outdated statutes sought to be regulated under the Health Disciplines Act. Hospital administrators and other employer groups expressed frustration with the restrictions the existing system placed on their ability to utilize health care providers efficiently. Government realized that coordinated policy direction of all health professionals was unattainable under the existing system (Schwartz, 1989: 2).

The Review stated that the intent of the Regulated Health Professions Act would be to benefit the public interest, not the interests of the profession. The public interest is to be cultivated in the following ways. The public is to be protected from unqualified, incompetent and unfit health care providers. (Schwartz, 1989: 4) The self-regulatory colleges would develop mechanisms that encourage the provision of high quality care. This new legislation is intended to permit the public to choose health care providers from a wide range of safe options. The Review believed that its recommendations would produce a better regulatory system. The new scope of practice/controlled act system would provide better public protection while permitting more efficient and cost-effective delivery of health care services.

A larger number of regulated health professions - new as well as traditional professionals; predominantly female as well as predominantly male professions - would have equal status and a public policy forum in which to express their views. Colleges would have the powers necessary to regulate health professionals effectively, and would be more accountable to the public for how they exercise their powers. This was to be accomplished through the increased participation of public members on Councils and open, public discipline hearings and Council meetings.

The traditional model of exclusive professional licensure was difficult to enforce. Colleges relied on complaints to identify offenders. This method is reactive, sporadic and lacks credibility with the public. Also, the exclusive licensure model established a hierarchical and, therefore, unequal relationship between licensed and registered professions (Schwartz, 1989: 14).

Nine health Ministers, over 11 years, representing all political parties chose to advance the reform principles put forward by the 'Review.' By recognizing a number of health occupations as professionals, the new legislation challenges the long established social structure of the dominant professions, and their authority.

Regulated Health Professions Act

The Regulated Health Professions Act 1994, as new legislation, was meant "to drag the regulatory system up from the feudal system to more accurately reflect current realities" (D.E. Wagner, 1993). At first glance, it would appear that the Regulated Health Professions Act more equally distributes the power among health care workers. The naming of the Act appears to reflect equity. The legislation is called the Regulated Health Professions Act, not the Regulated Health Occupations Act, so it seems, at least in name, that the presently subordinate occupations, primarily female, have been elevated to an equal position with the dominant professions such as medicine, dentistry and optometry which are predominantly male. Seventy percent of the persons regulated by the R.H.P.A. are female. Thus, it would appear that all professions within this Act are on an equal playing field.

The R.H.P.A. allows for the emergence of new discourse and new ways of delivering health care. This affects the public at all levels as twenty four health occupations are brought together under one piece of legislation. Each has power over some part of the body. Medicine has, in the past, had power over all parts of the body (although they relinquished the mouth to dentistry) and determined who was delegated what task. The autonomy of the licensed professions of the Health Disciplines Act (Medicine, Dentistry, Pharmacy and Optometry), is threatened as midwives, dental hygienists, nurse practitioners, and optical dispensers emerge. Hopefully, the emergence enables consumers to choose providers and to choose the entry point into the health care system. It is also hoped that the regulated health professionals will work collaboratively to provide effective coordinated services.

The R.H.P.A. scope of practice model is intended to protect the public while avoiding the disadvantage of exclusive licensure. The model consists of three main elements. Every profession specific Act contains a general statement describing, but not licensing, the profession's scope of practice. The statement generally provides three types of information about the profession; what the profession does, the methods it uses, and the purpose for which it does it. For example, the scope of practice of dental hygiene and dentistry are stated as:

> The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services (Dental Hygiene Act, 1991).

> The practice of dentistry is the assessment of the physical condition of the oral-facial complex and the diagnosis, treatment and prevention of any disease, disorder or dysfunction of the oral-facial complex (Dentistry Act 1991).

The Health Professions Procedural Code of the R.H.P.A. sets out the full list of licensed/controlled/authorized acts expressed as thirteen categories (Appendix D), together with provisions prohibiting the performance of licensed acts by persons other than the health professional authorized to perform them (Schwartz, 1989: 15). The profession specific acts include the controlled acts specific to each profession.

For the purpose of this discussion, this paper will focus on controlled act #2,

> Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth including the scaling of teeth (R.H.P.A., 1994: 8).

a portion of which can be carried out by dentistry or dental hygiene.

The authorized/controlled/licensed acts in the Dental Hygiene Act are:

> 4. In the course of engaging in the practice of dental hygiene, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:
>
> 1. Scaling teeth and root planing including curetting surrounding tissue.
>
> 2. Orthodontic and restorative procedures.

The area of the Dental Hygiene Act that has created the confusion and the subsequent request of the C.D.H.O. of the Minister for an amendment to the Act is:

> 5. (1) A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario.
>
> (2) In addition to the grounds set out in subsection 51 (1) of the Health Professions Procedural Code, a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member contravenes subsection (1).
>
> (Dental Hygiene Act, 1991)

The R.H.P.A. does not address the term 'order.' As it is not defined in the R.H.P.A., it could be said that the language of the R.H.P.A., reflects equity. However, the profession specific acts do not reflect equity as none of the male dominated professions has 'order' in its profession specific Act.

The Regulated Health Professions Act is a social construct that has arisen from particular interests which have histories. These particular interests, eg., dentistry, dental hygiene, are themselves products of histories. The reality of this legislation is a product of thought and practice manifesting a particular set of power relations. It is a manufactured object of knowledge that has been produced by our discourses and practices as a result of these power relations. Thus, the R.H.P.A. is an anchorage point that is supporting the current practices of health occupations. As a result of passage of this legislation, delivery of health is objectified. Thus, the R.H.P.A. manufactures a legitimate object of inquiry for a sociological endeavour.

The Regulated Health Professions Act marks the inscription of a contest of ideas, a contest of political subject. The truth of the R.H.P.A. is political at the broadest level. It is an example of power relations as resistances and struggles emerge.

In its struggle to attain total regulatory independence and consistency of governance in all dental hygiene practice settings, the Transitional College of the Dental Hygienists of Ontario proposed that section 5 be amended as follows:

> 5. (1) A member shall not perform a procedure under the authority of section 4.1 unless:
>
> (a) the performance of the procedure by the member is permitted by the regulations and the member performs the procedure in accordance with regulations; or
> (b) the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.
>
> (1a) A member shall not perform a procedure under the authority of section 4.2 unless the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.

The rationale for proposing the amendment was that the authorized acts of scaling teeth and root planing, including curetting surrounding tissue, can be done properly by dental hygienists independently in definable circumstances. The independent performance of scaling is analogous to certain Nursing acts. Thus, the proposed amendment was modelled on the Nursing Act, 1991, adopting the approach of setting out the circumstances in which the act can be independently performed in the regulations. The Transitional Council of the C.D.H.O. believed that an amendment to the Dental Hygiene Act reflected current dental hygiene practice in private dental offices and equity in public health and private dental practice settings. Also, self-initiation by dental hygienists, the Council agreed, would increase consumers' options for access to oral health care.

The R.H.P.A. procedure code sets out the objects of each regulatory College 3(1):

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the Regulated Health Professions Act, 1991 and the regulations and by-laws.

2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.

3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing competence among the members.

5. To develop, establish and maintain standards of professional ethics for the members.

6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the Regulated Health Professions Act, 1991.

7. To administer the health profession Act, this Code and the Regulated Health Professions Act, 1991 as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

8. Any other objects relating to human health care that the Council considers desirable.

(R.H.P.A., 1994: 22-23)

The duties of the Minister are as follows:

It is the duty of the Minister to ensure that the health professions are regulated and coordinated in the public interest, that appropriate standards of practice are developed and maintained, and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professions, the College and the Board (R.H.P.A., 1994: 2).

The Health Professions Regulatory Advisory Council (H.P.R.A.C.) provides advice to the Minister of Health (R.H.P.A., 1993: 4-5). H.P.R.A.C. interprets its role and responsibilities as being carried out, to support the Minister in ensuring regulation and coordination of the health professions in the public interest. In formulating its decisions, H.P.R.A.C. believes that the public interest is promoted by the following principles underlying the R.H.P.A.:

- quality of care (measured by standards)
- accountability (through effective structures and mechanisms)
- accessibility (in each of its forms: geographic, linguistic, barrier-free, etc.)
- equity (in the availability of opportunities for health)
- equality (among health professions).

(H.P.R.A.C., 1994: 1)

As stated in the background chapter, the number of public members appointed to the health professions regulatory bodies is just under 50%. Public members are expected to represent consumers' and the general public's viewpoint in the deliberations and decisions of the Colleges' Councils. Through their participation, public members are expected to ensure that decisions made optimize public safety and avoid unwarranted restriction of consumer choice. Thus, it would appear that public interest is to evolve from merely 'do no harm' to social justice in health care.

Through the discourse of the R.H.P.A. and the profession specific Acts, a new type of equity and equality among different health professions hopefully will emerge. Increased choice for safe options for consumers will also be created. However, the differential access to power and decision-making among the previously legislated groups such as dentistry is, in fact, replicated to the extent it is effectively able to lobby to maintain professional dominance under the new legislation.

Dentists are not required by statute to issue 'orders.' However, dental hygienists are statutorily required to receive them. Other professions, such as nurses and medical laboratory technicians which are subject to orders work in hospitals or institutions which are governed by separate legislation requiring established protocols and traceable lines of authority (Page, 1995).

Power/Knowledge

The functioning of a discursive regime essentially involves forms of social constraint which include valorization in some statement forms, the institutional licensing of some persons as being entitled to offer knowledge claims and the concomitant exclusion of others. The May 25th meeting, convened by the Professional Relations Branch of the Ministry of Health, and the

H.P.R.A.C. submissions are examples of the way power circulates in and through the production of discourses in society.

Dentistry claims that dental hygiene is not educated/trained to diagnose, assess, problem-solve or self-initiate. Only dentistry, with its longer education/training, can identify when it is safe for a dental hygienist to proceed with scaling and root planing. Dental hygiene, having been enabled, thus gaining some freedom and autonomy through the new legislation, is able to formally resist dentistry's claims, at least, in public forums.

Regulation of the mouth up to January 1, 1994, represented a particular discourse and knowledge. The mouth had been established as a socially significant object. Not only has the independent existence of the mouth been accepted, but also the experience of disease and hence the demand for treatment. The requirement for dental care was created through a process of normalization which incorporated a whole series of techniques of knowledge that created a new region of dental disease through the conception of dental health.

> Dentistry has been regulated by the R.C.D.S.O. since 1868. Dentistry, like medicine, was organized on a broadly inclusive basis, gathering in all those no matter what their qualifications, who could establish a claim to be practitioners ... Collegial self-government, control over the conditions of work, the power to set educational standards, and the exclusion of unlicensed practice - what had begun as a straightforward manifestation of the protective impulse had ended with all the trappings of a learned profession ... one did not 'study' dentistry; there was no elaborated body of knowledge, no curriculum to be pursued, no body of texts to be mastered. To give dignity to the profession this had all to be invented in the years after 1868 (Gidney & Millar, 1994: 218-219).

"For 42 years, the R.C.D.S.O. also regulated the profession of dental hygiene. This function ceased on January 1, 1994, with the proclamation of the Dental Hygiene Act, 1991" (R.C.D.S.O., 1995). As might be expected, dentistry is not about to give up its established control and the economic benefits without a strategically well fought battle.

On May 25, 1994, the R.C.D.S.O. made a verbal statement opposing the Professional Relations Branch Ministerial process, but did not make a verbal presentation as they opposed the process. However, prior to May 25th, the R.C.D.S.O. sent a written submission which appears to be reflected in the P.R.B.'s summary. The R.C.D.S.O. submission argued that the public would be at risk and the quality of dental care reduced if the proposed Dental Hygiene Act amendment were supported because dental hygienists are not sufficiently educated to decide when to proceed with scaling and root planing:

> ... dental hygiene education does not prepare dental hygienists to diagnose or to screen out patients with medical or dental contra-indications ... The ability to decide that the procedure should be performed is linked to the ability to make a diagnosis and to identify patients for whom the procedure is unsafe or inappropriate ... In Ontario, dental hygienists undergo nine months of dental hygiene training. This follows graduation from a dental assisting program of a maximum nine months duration. During the dental assisting program, students are taught skills which assist the dentist at chairside. They are not taught assessment or independent problem solving skills. Only during the nine month dental hygiene training period do students learn the technical aspects of scaling and root planing. There is insufficient time during their training to give them more than a very limited introduction to taking and interpreting medical histories or to develop the problem solving skills essential to be able to work independently. There is also no time to give them the

> diagnosis and treatment planning skills that dentists acquire during four years of dental school. In summary, the dental hygiene curriculum gives dental hygienists technical competence and limited assessment skills, while it barely touches on diagnosis and treatment planning (R.C.D.S.O., 1994).

The specialty dental professions that presented on May 25th would have the audience believe that:

> unless a professional had been trained not only to recognize but to deal with virtually every potential situation, that professional ought not to be allowed to commence even the simplest treatment (Wagner, 1994: 6).

The room reeked of élitism on May 25, 1994. As the C.D.H.O. legal counsel said to the gathering, "There's enough money in jewellery and suits here today to fund the Shout Clinic for a year." The lone consumer in the group having watched the periodontists slides and listened to the presentation said, "Where are all the real people today? If the average person saw all those slides, they would never go to a dentist at all."

Dentistry's educational élitism was addressed in the C.D.H.O.'s follow-up submission:

> One of the most memorable instances of this élitism was the case involving one of the tumours cited by the Ontario Society of Periodontists. The example was intended to demonstrate that without a dentist's level of training in oral pathology one ought not to perform any oral procedure because assessment demanded that one be able to identify sometimes subtle changes in tissue. The speaker stated that dental hygienists could not assess oral health because they would not have noted the particular change. By this standard, most primary care dentists, a number of dental specialists, and a significant number of specialist physicians would have to be denied the right to assess too, because the speaker acknowledged that most of them would have or did miss the condition too (Wagner, 1994: 6).

Unlike dentistry, which is taught at two universities in urban areas of Ontario, Toronto and London, dental hygiene education and training takes place in ten communities throughout the province. Dental hygiene students interact with other students and clients from various socio-economic, cultural and ethnic groups. Since the Community College system offers a variety of occupational courses besides health care, students are educated/trained and socialized in a heterogenous environment. This exposure to different occupations prepares dental hygienists for the complexities of communities.

Unwittingly, dentistry has been losing control of the dental hygiene programs. Dentistry's control of the education curriculum and faculty at the University of Toronto was an effective social control which enforced the occupational hierarchy in dental practice. As a result of pressures from dentistry many years ago for increased numbers of a more flexible auxiliary, dental hygiene was moved to the community colleges. Ontario Community Colleges introduced a ladder approach to dental hygiene education. The first year of training provides the requirements for dental assisting. However, the Canadian Dental Commission on Accreditation has accepted the dental assisting program as the foundation year for dental hygiene. Further, dental hygiene has evolved from dentistry's list of duties to a process of care with the introduction of the <u>R.H.P.A.</u>

> Didactic and clinical courses are delivered in a manner which reinforces a "Dental Hygiene Process of Care" that encompasses assessment, planning, implementation and evaluation of both therapeutic and preventive procedures.

> This model incorporates skills such as decision-making, problem-solving and critical thinking. A high regard for the legal and ethical expectations of the profession are stressed continually, as are the values of responsibility and accountability for an individual's action.
>
> The students are exposed to clinical experiences that are client-centred and comprehensive in nature. This means the students must identify the client's needs, plan appropriate treatment with expected outcomes, assess their abilities to provide the required treatment and then decide to proceed with treatment or make the appropriate consultations or referrals. This experience is carefully guided by registered Dental Hygienists who serve as teachers, resources and role models (C.D.H.O., 1995a: E3).

Georgian College in Orillia addresses the students instruction in medical history taking:

> The course of Dental Medicine provides students with the theoretical background on how to relate the medical history to potential risks for the client or emergency situations that may arise in a dental environment. This course also deals with pharmacology, addressing the various kinds of medications a client may be on and the implications both medically and dentally. The course of Periodontics connects the information gathered from a medical history with the clinical considerations for treating periodontal diseases.
>
> In the clinical environment, the students are required to complete a comprehensive medical history on each client. This history is discussed with the client for verification. The students are required to complete drug cards on all medications (prescribed and over the counter) the client is taking. The card identifies the purpose of the drug, the indications, contra-indications and any dental considerations. If the medical history is unclear or the client is unsure of the medications, the student is expected to contact the appropriate professional, ideally the client's physician or the dentist on staff to get clarification or direction. The students must present the completed medical history to the Clinical Dental Hygiene Instructor for discussion and approval (C.D.H.O., 1995a: E4).

It would appear that dental hygienists enter practice trained in decision making.

> The skills of problem-solving and decision-making are intrinsic to the didactic and clinic components of the dental hygiene curriculum. Students are expected to be able to make decisions, based on sound scientific principles, for all aspects of care from assessment to treatment and follow-up. Students need to be able to support and explain all findings and recognize when more information is required. Students are seen as accountable for their actions/inactions and accept that responsibility (C.D.H.O., 1995a: E5).

Dentistry contradicted the C.D.H.O. statement that the proposed Amendment would increase the public's choice and ability to access preventive services:

> There is absolutely no barrier to dental hygienists working in the community in collaboration with dentists. It is the norm for dentists to base their practices in the community, and a great many dental hygienists work in these community-based practices at present. There is no shortage of dental professions in Ontario, including the North (R.C.D.S.O., 1994).

Also:

> ... A review of the practitioner-to-population ratio shows that dentists are available in virtually every community across the province. Given that Algoma, Sudbury, Nipissing, Kenora, Rainy River and Cochrane have the same dentist to population ratio as Waterloo, Brant, Durham and Peterborough (about 1:2,000 or 2,500); and that Thunder Bay has the same dentist to population ratio as Hamilton-Wentworth, Halton, Peel and York (about 1:1501 or 1,999), it is difficult to understand which northern communities the dental hygienists are targeting (O.D.A., 1994).

This statement does not account for the fact that Northern Ontario has 80% of the land mass and 10% of the population of Ontario. Ratios on a piece of paper do not account for geographical distances or other environmental barriers which prevent people from seeking services. The C.D.H.O. referred to Croucher's study which showed that socio-economic barriers exist which prevent equitable, accessible utilization of dental services.

There is differential access to services by area of residence, income and education (Croucher, 1988: 349).

Manga and Campbell note that greater access to hygiene services could go a long way to improving the oral health of the public and thus decrease the need for costlier, more complex treatment by dentists (Manga and Campbell, 1994: 27). Barriers often exist, not because of their innate legitimacy, but because they serve the vested interests of an élite, dominant group. Another barrier is the primary reliance on solo, or group fee for service practice, and the relative lack of health care delivery systems such as community health centres (Manga and Campbell, 1994: 16).

In a written submission to the P.R.B. for May 25th, the Canadian Federation of Labour supported increased access to dental hygiene services and, therefore, the proposed amendment:

> The Canadian Federation of Labour promotes affordable, accessible health care, a significant portion of which focuses on prevention. We also strongly support systems which ensure that the appropriate health professional is providing the right service in the right situation.
>
> As written, the Dental Hygiene Act does not follow these principles as a dentist must 'order' a dental hygienist to scale and clean teeth. Effectively, the dental patient is obliged to pay for the service of a dentist as well as the dental hygienist who is independently qualified to perform the work. The Canadian Federation of Labour finds this to be unnecessary, expensive and a deterrent, especially to people with low incomes.
>
> We are disturbed to learn of a survey that found that more than 20% of Ontarians said they could not visit a dentist because it was too expensive; furthermore, that 31% of people in Ontario had no dental benefits (Ontario Health Survey, 1990). It is inexcusable that the Dental Hygiene Act supports a system whereby preventive dental care is unaffordable to many Ontario citizens (McCambly, 1994).

The Legislature was not to reconvene from the Summer Recess until October 25th, one of the longest recesses in recent history. It was to rise for Christmas break around mid-December and was not expected to be reconvened again until late March 1995. With such a timetable, it was important that the amendment be tabled for First Reading in the Fall of 1994 and every effort made to have it passed. Otherwise, with an election to be held by September 1995 and the expectation of a change in the political party in power, the matter would have to start again with a new cast of players with different objectives and priorities. Dentistry, no doubt, was aware of the timetable and their strategy was to "play out the clock."

Resistances persisted as a result of the Minister's statement on June 8, 1994, during the debate in the legislative committee on Estimates.

> But I know the concern of the dental hygienists and am happy to be able to tell the committee that, as an interim measure, the C.D.H.O. and the R.C.D.S.O. have come to an agreement which allows dentists to issue a general, rather than a case-by-case specific, order for most procedures. I certainly hope that agreement will allay some of the concerns of the dental hygienists and enable them to carry out their practice as they've wished to do and as they have in many cases been doing in the past (Grier, 1994: 470).

Legal Counsel for the C.D.H.O. responded to the comments:

> Minister, if you have been told that the urgency of the need for legislative amendments has been eliminated, we believe you have been misinformed. The R.C.D.S.O. has accommodated public health dental hygiene programs, albeit only after some delay. As well, also in response to Ministry pressure, they have agreed to accept our temporary solution of a standing order or protocol ... The reluctant, delayed acquiescence of the R.C.D.S.O. to an order regulation that accommodates only the most

> obviously worthy of the Ministry and dental hygiene demands, combined with an unwillingness of many dentists to cooperate by giving 'orders,' does little to remove the urgency to address this problem through a legislative amendment (Wagner, 1994).

Perhaps dentistry lobbied the politicians more effectively in the summer of 1994 than did dental hygiene. The 'order' issue became politicized. The Minister of Health had been effectively brought to task and embarrassed by the opposition health critics in the Legislative standing committee on Estimates on her position to have the dental hygiene amendment dealt with through the Ministerial route rather than through the H.P.R.A.C. referral process.

> We are therefore disturbed to learn that the H.P.R.A.C. process is to be short-circuited through the direct decision of the Minister of Health regarding potential amendments to the Dental Hygiene Act. This process change adds to concerns about integrity of the process and further adds to concerns about predictability and stability in the system (Sullivan, 1994: E468).

Dentistry was satisfied that the Government would not put forward an amendment after the Minister's words on June 15, 1994:

> I did not see at this point opening up the R.H.P.A. certainly in this session, perhaps not in the next one, that as we learned how to deal with the R.H.P.A. and as the professions become more familiar with it, there might be a package of changes required to be made at some future date (Grier, 1994: E507).

Pleased with the fact that no amendment would be forthcoming, the R.C.D.S.O. withdrew its request for a referral of the dental hygiene 'order' amendment matter to H.P.R.A.C. Dental hygiene, on the other hand, realized that with a provincial election soon to be called and the probability of an N.D.P. defeat, the 'order' issue would die without published recommendations from H.P.R.A.C. So, quickly and quietly, to avoid submersive action by dentistry, dental hygiene reactivated its request for a referral to H.P.R.A.C.

This jostling of positions revealed that the emerging regulated health occupations lack experience in lobbying and do not have the same access to resources as the established dominant professions.

> They tend to be articulate spokesmen for their causes, skilled in the art of lobbying at legislatures and at justifying their position to the public. Their task in lobbying and self-justification is no doubt made easier by the fact that the leaders of one profession often have close personal contacts with the leaders of other professions ... (Bohnen, 1975: 25).

However, the Minister did refer the matter to H.P.R.A.C. with a request for recommendations by April 30, 1995. H.P.R.A.C. sought written submission from interested parties by February 28, 1995, with opportunity to respond to other submissions by April 18, 1995.

Dentistry has been viewed as being dominated by a cohesive group of professionals who display the appropriate social and political convictions. A certain ideology has been ascribed to the mouth and mouth care.

> This was the ideology of free enterprise, competition, fee for service, and the positive results to be had from the pursuit of self-interest (Weller, 1974: 94).

If H.P.R.A.C.'s analysis concludes that there is no rational relationship between the 'order' requirement and the goal of protecting and promoting the public's oral health, then recommendations for some mechanism to allow dental hygienists to self-initiate, i.e., proceed without an 'order,' will go forward to the Minister of Health. Dentistry, no doubt, will initiate new strategic games so it can continue to determine the conduct of dental hygiene practice.

Professional Dominance

The discourse of professional dominance is hierarchical and exclusionary for users as well as providers of health care services (Friedson, 1970; Grant, 1988) as generally there are gender, social and cultural differences between user and provider.

> Domination of the professions by particular socio-economic groups is disturbing from a consumer perspective if it is believed that who professionals are affects the kinds and the quality of the services they provide ... Anglo Saxon ... doctors may fail to recognize the cultural components of illnesses ... they are asked to cure (Bohnen, 1975: 26).

At the public consultation meeting held in May 1994, a health promoter at the Shout Clinic, an organization which works with street youth, stated that:

> Many marginalized populations have limited access to health services that most of us consider to be universal. Street involved youth are one such population; a group of young people who because of poverty, an unstable lifestyle and structural constraints within the health care system, have generally suffered from a dual handicap of a higher risk of illness and at the same time, a lesser ability to access services (Gaetz, 1994).

Diminishing professional dominance and dismantling the medical curative/treatment model by reforms of the self-regulatory system by state authority is the key to affordable, accountable, accessible health care services.

> It is probably true that one stroke of effective health legislation is equal to many separate health intervention endeavours and the cumulative efforts of innumerable health workers over long periods of time (McKinley, 1981).

Under the Health Disciplines Act, professionals such as physicians and dentists were licensed to perform exhaustive scopes of practice. As long as they were in good standing with their regulatory/governing College, they maintained those licenses for life. No mechanisms, other than the Complaints process, were in place to assure that they practiced safely and competently. The Review put forward a new system. The new system consists of a list of thirteen controlled acts, in the legislation, which were determined to cause risk of harm or irremediable consequences when performed inadequately (Appendix D). As stated previously, dentistry and dental hygiene share controlled act #2. Dentistry claims that there would be a risk of harm to the public if dental hygienists proceeded without 'orders.'

Although the R.H.P.A. contains no regulation making authority dealing directly with 'orders,' the R.C.D.S.O. chose to draft such a regulation. The original R.C.D.S.O. position in the summer of 1993 insisted that an 'order' from a dentist be patient specific. The C.D.H.O. pointed out that an interpretation of Section 5 of the Dental Hygiene Act needed to include the concept of a 'standing order' or 'protocol' if the public health programs were to be kept intact when the R.H.P.A. was proclaimed (Page, April 18, 1994).

On June 23, 1994, the R.C.D.S.O. Council passed this 'order' regulation.

> (1) In this section, 'order' means the authorization required by a member of the College of Dental Hygienists of Ontario pursuant to section 5 of the Dental Hygiene Act, 1991 or a member of the College of Nurses of Ontario pursuant to section 5 of the Nursing Act, 1991, to permit the controlled acts

authorized to members of those Regulated Health Professions.

(2) A member may provide an order to a member of the College of Dental Hygienists of Ontario for one or more of the following:

1. Scaling
2. Root planing.
3. Subgingival curetting of surrounding tissue in conjunction with scaling or root planing, not including surgical curettage.
4. Placing and removing arch wires previously fitted by a member of the Royal College of Dental Surgeons of Ontario.
5. Separating teeth prior to banding by a member of the Royal College of Dental Surgeons.
6. Cementing and removing bands or brackets or both for orthodontic purposes that have previously been fitted by a member of the Royal College of Dental Surgeons of Ontario.
7. Taking impressions for working models for the fabrication of appliances for orthodontic or space maintenance functions.
8. Placing, cementing and removing passive space-maintaining appliances that have previously been fitted by a member of the Royal College of Dental Surgeons of Ontario.

(5) A member may provide an order for a patient under his or her care

(a) where the member has first personally reviewed the current medical history of the patient and determined that there are no contra-indications to the patient's treatment; or
(b) where the member has not personally reviewed the current medical history of the patient, such an order shall be subject to the following conditions and no authorized act shall be carried out pursuant to the order unless and until:

    1. a current written medical questionnaire, the form of which is approved by the member providing the order, is obtained in respect of the patient and all of the responses to the questions are in the negative, indicating that the patient is not medically compromised and that there are no contra-indications to treatment; or

2. where all of the questions are not answered in the negative, thereby indicating that the patient may be medically compromised or that there may be contra-indications to treatment:

(i) the confirmation by the member who originally provided the order is obtained, such confirmation being given after the member has considered the patient's medical history; or

(ii) a member of the College of Physicians and Surgeons of Ontario has provided medical clearance for the proposed treatment of the patient.

To convince the Ministry that the proposed amendment would provide safe oral health care options, it would be necessary to persuade the Ministry of Health and H.P.R.A.C. that dental hygienists have the skill, knowledge and judgement to know when and when not to self-initiate. It would be necessary to convince H.P.R.A.C., bureaucrats and legislators that dental hygienists are trained/ educated to recognize contra-indications and initiate treatment only in appropriate situations.

Dentistry continues to assert that dental hygienists are unable to take a medical history, use it in conjunction with the assessment of the client's teeth and surrounding tissue and recognize the existence of, or possibility for, contra-indications for proceeding with scaling and root planing. Continuing its resistance, dental hygiene states that dental hygienists in Ontario are educated/trained to provide this level of care. C.D.H.O. asserts that dental hygienists have been working to this standard of professional judgement in private and public practice settings for years with no known risk of harm to the public. The C.D.H.O.

has not claimed that dental hygienists' diagnostic or decision-making ability or need is the same as that of dentists. They do not need to know everything, or be able to deal with all possibilities. However, it has been shown that their education is sufficient for them to safely judge whether to self-initiate scaling and root planing; or whether, instead, to refer the client to a dentist or physician.

Although the dominant profession claims to diagnose each patient, a differential diagnosis is rarely done. Usually an assessment is made, not a conclusive statement about the etiology of the patient's condition, disease or pathology. However, communicating the diagnosis remains a controlled act of dentistry.

Assessment is included in the dental hygiene scope of practice. Practically every health practitioner assesses a client's condition before proceeding with the appropriate procedure. Assessment involves decision-making based upon the collection and critical analysis of data.

Schwartz stated in a letter to the R.C.D.S.O. in 1987:

> What the Review does <u>not</u> intend to restrict through the licensure of "diagnosis" is the ability of others to assess their patients or clients, as they do now. We recognize that undertaking treatment of any sort in the absence of an assessment would be improper practice, and would fall below the standards of care of any profession.
>
> In recognition of this fact the proposed general scope statements of any professions include the word "assessment." The Review believes that the proposed system will not in any way impede practitioners not licensed to diagnose from assessing their patients or clients to determine the applicability of a particular range of treatments and from undertaking a course of treatment in appropriate situations. As is the case today, if the treatment has no beneficial effect, or if

> the patient continues to deteriorate, further investigation is undertaken or, where appropriate, a referral to another profession is made.
>
> In our view, a diagnosis is rarely necessary or in fact done. We believe ... that an assessment, rather than a diagnosis is precisely what a physician or dentist does in most cases (Schwartz, 1987).

In recent submissions to H.P.R.A.C. regarding the proposed amendment to the Dental Hygiene Act, the various dental organizations argued that dental hygienists are not trained/educated to proceed without a dentist's 'order.' The dentists' argument against dental hygienists self-initiating scaling and root planing is that, although the dental hygienist may have the technical skills to perform the procedures competently, they are not able to decide if, and/or when, the procedures should be carried out. For instance, the specialty group of orthodontists stated:

> How is it possible for a dental hygienist with nine months training in his/her profession to have the competence to make decisions regarding a patient's diagnosis and treatment plan, which has taken a general dentist five to seven years to become competent (Doucet, 1995).

This statement by the orthodontists is disputed by dental hygiene as:

> a highly distorted and unfair comparison which ignores the fact that dental hygiene education is a complex two-tiered system. Dental hygienists in Ontario are required to have a year of dental assisting training, usually followed by a year of clinical practice, before taking their year of dental hygiene education. A fairly stated comparison between the education programs for the two professions would count somewhere between two and three years for dental hygienists as compared with five years for dentists. Of course, this differential results from the fact that dental hygienists do not aspire to the practice of dentistry. The differential itself is

> irrelevant to the question. What is relevant is the course content during the two academic years (C.D.H.O., 1995).

The Royal College of Dental Surgeons exhibits dentistry's self-aggrandizement and persistent position:

> ... when H.P.R.A.C. asks if the dental hygienist has the same abilities as a dentist to determine if an individual is 'healthy,' the answer is clearly negative. The dental hygienist by virtue of having acquired a much narrower knowledge base during training, does not have the knowledge to fully assess a patient and determine that it is permissable to proceed with treatment ... (R.C.D.S.O., 1995).

The Ontario Society of Periodontists supported the other dental organizations' argument that no public benefit is gained if dental hygienists are allowed to self-initiate the authorized acts of scaling and root planing including curetting of surrounding tissue:

> ... self-initiation would risk a decline in the level of periodontal health of the public due to a lack of adequate training and educational experience on the part of dental hygienists. We believe dental hygienists are unable to adequately apply and interpret the measures of periodontal disease which are necessary prior to initiation of the authorized acts of scaling and root planing ... (Sutherland, 1995).

Research has shown that there is no necessary correspondence between superior credentials and client care (Benoit, 1994). However, dentistry has taken the position that unless the dental hygienist has been trained to recognize and to deal with virtually every potential situation, then the dental hygienist should not be allowed to proceed without an 'order' from a dentist. This is an élitist dominant position and such an attitude does not comply with the principles upon which the R.H.P.A. was based. It also ignores practical and economic realities in the delivery of health care (Wagner, 1994).

The dentists' submissions ignore the changes in dental hygiene education as the profession has prepared itself for self-governance. Changes in the teaching programs reflect the image of dental hygienists as self-governing. The dentists' arguments reflect the hierarchical professional dominant view. The R.C.D.S.O. continues to view the dental hygienist as an auxiliary employee who performs a "list of duties" for, and by implication under the supervision of, a dentist. A related example of this outdated view is that the O.D.A. submission quotes from the 1976 edition of <u>The Clinical Practice of the Dental Hygienist</u>, a text book generally used in dental hygiene programs. Social and professional norms have changed radically in the intervening nineteen years, and such a quote will not be found in the more recent editions of Wilkins' text (C.D.H.O., April 1995).

The C.D.H.O. believes that it is not necessary for each regulated profession to be in a position to know and handle everything. What is necessary is that each dental hygienist know his or her own limitations and that of the profession and that each ensures that they do not put themselves and/or their clients in situations where there is an unnecessary or inappropriate risk (Wagner, 1994).

The educational élitism that is expressed in the discourse of the dental organizations' submissions to H.P.R.A.C. helps to explain the agonism and resistance. In fact, dental hygiene students come into their profession from a wide range of backgrounds. Many have previous degrees or qualifications in other fields. A common motivation for those entering the dental hygiene profession is participation in a prevention oriented field. They do not want to be involved primarily in treatment and repair (C.D.H.O., April 1995).

In her letter to H.P.R.A.C., Linda Furst documents a recent personal experience where, in a proposed geriatric practice, she was prepared to work on the authority of a written order obtained from an absentee (retired) dentist which would be obtained on the basis of a medical history confirmed by the patient's physician. However, the R.C.D.S.O. indicated a "preference" that the dentist see each patient. Subsequently, the R.C.D.S.O. <u>insisted</u> on this course of action, requiring as well that the dentist issue a bill for both the examination and the 'order' - a condition that made the project unworkable (C.D.H.O., April 1995). Ms. Furst's proposal parallels in private practice what the R.C.D.S.O. has permitted in public health. This illustrates the R.C.D.S.O.'s continuing support for a double standard between private and public dental practice. The R.C.D.S.O. has been known to regulate by exception and accommodation for particular public health dentistry programs. The R.C.D.S.O. response to Furst's proposal,

> seems to confirm the suspicion that a financial interest is at the heart of the dental profession's concern for maintaining the dentist's gatekeeping role in the provision of dental hygiene services, and is a good example of how the present situation virtually prohibits dental hygienists from working in non-traditional community practice settings (C.D.H.O., April 1995).

The present attitude of the R.C.D.S.O. does not reflect the intent of the legislation to increase the public's access to alternate providers in non-traditional work settings in communities.

Technologies of Bureaucracy

> Control by small groups is facilitated by bureaucratic organization. Bureaucracy is the concentration of administrative power within the machinery of hierarchial coordination ... Bureaucratic organization is therefore a power instrument par excellence (Porter, 1965: 220).

Institutions such as the teaching institutions, the Royal College of Dental Surgeons, the Ministry of Health, and the Professional Relations Branch within the Ministry of Health are examples of bureaucracies. Since the C.D.H.O. and the H.P.R.A.C. are recently established through the new legislation (R.H.P.A.), these organizations have not had time, or perhaps the inclination, to model themselves on the traditional bureaucratic, hierarchical structure. The research to date indicates that professional dominance is reinforced through bureaucracies. Also, these bureaucracies tend to further the status quo.

Politically, the more established occupations (particularly dentistry) have tended, to one degree or another, to resist this new legislation (Coburn, 1993: 136).

Dentistry is one example of the dominant professions within the R.H.P.A. that is fighting fiercely through its many bureaucracies to maintain the status quo.

On October 22, 1993, the C.D.H.O. wrote to the Minister of Health, Grier, advising her of the problem with the word 'order,' and asked the Minister to amend the Dental Hygiene Act to resolve the situation "in a manner consistent with the public interest in the area of Dental Hygiene" (Page, 1993a). On November 10, 1993, the Director of the Professional Relations Branch of the Ministry of Health and members of his staff brought the C.D.H.O. and the R.C.D.S.O. together in an attempt to accommodate the positions. The Ministry officials made it clear that no regulations would be put in place that jeopardized the public health programs.

> Colleges may, where the authority exists by statute, make regulations related to orders, but the policy content of these regulations must not be self-serving, unduly restrictive, or contradictory to government policies or programs. ... order must not be interpreted in any way to jeopardize the status quo in the delivery of public health dental and dental hygiene programs (Burrows, 1993a).

The C.D.H.O. had been told that no amendments would be made to the Acts before proclamation. However, the C.D.H.O. decided to "press on" as though the possibility existed. Given the fact that no amendments were to be made, it was interesting for the C.D.H.O. to note that a government amendment to Bill 100 was included and passed on December 13, 1993, with no consultation. The amendment, although included in Bill 100 (Sexual Abuse), related not to sexual abuse but to Quality Assurance, a separate statutory committee under the Regulated Health Professions Act. The most efficient way to affect this amendment was to enter it under Bill 100 which had all party approval. No one seems to know where these regulation-making powers for the Quality Assurance Committee, which are now in Bill 100, originated, but many think it was the lobbying power of medicine's regulatory bureaucracy, the College of Physicians and Surgeons of Ontario.

In response to the Ministry's request to clarify the position and needs of the Public Health Programs, a meeting was held on November 24, 1993, initiated and hosted by the C.D.H.O. At that meeting, it was still the R.C.D.S.O. position that a "general order" was not in accord with the apparent intent of the wording of Section 5 of the Dental Hygiene Act.

An internal memo circulated among Senior Dental Public Health Officials stated:

> there did not appear to be any further benefit to the public health by requiring a dentist (public health or private) to review a "clear" medical history ... The issue is that the proposed regulation would restrict traditional public health services. The intent of the Act was exactly the opposite. Acceptance would effectively limit public access, especially to the most needy (Hicks, 1993) (Appendix E).

The Public Health dentists were still seriously at odds with the R.C.D.S.O. position regarding its interpretation of the word 'order.' Thus, the R.C.D.S.O. was forced to change its position from November to December and the two Colleges were able to agree about the need to implement a protocol approach to the word 'order' in the Dental Hygiene Act.

In its persistence, the Council of C.D.H.O., requested a meeting with the Deputy Minister of Health. For various reasons, the recent change in Deputy Ministers being one, the C.D.H.O. was granted a meeting with the Assistant Deputy Minister of Health on the morning of December 20, 1993. The C.D.H.O. was not advised prior to this meeting who would be attending on behalf of the Ministry. After the apparently usual 15 minute wait, the three Ministry officials arrived. They included two women, the Assistant Deputy Minister of Health and a legal counsel with the Ministry of Health, and, one man, the Director of the Professional Relations Branch, a key bureaucrat that the C.D.H.O. had been communicating with on a regular basis. Attending on behalf of the C.D.H.O. was myself, Don Page, the C.D.H.O. Registrar at the time, Linda Strevens, and adviser Jane Fulton.

On the afternoon of December 20, 1993, C.D.H.O. representatives met with representatives of the R.C.D.S.O. in an attempt to achieve a coordinated protocol to be sent to dentist and dental hygiene registrants in time for proclamation of the R.H.P.A. This was not achieved and the C.D.H.O., to facilitate the transition to self-governance and the 'order' regime, sent a sample protocol to all dental hygienists who would be registered and regulated by the C.D.H.O. on January 1, 1994. One week into January, the R.C.D.S.O. sent out a profession advisory which essentially said the same thing as the C.D.H.O. The Ontario Dental Association followed with another protocol and, in the President's letter to dentistry's membership in March 1994, stated:

> We do not feel that a protocol that expects hygienists to self-initiate treatment is appropriate under this legislation. Therefore, we strongly recommend that dentists do not sign C.D.H.O.'s protocol for dental offices (Sweetnam, 1994).

The flurry of advisories from the C.D.H.O., R.C.D.S.O., O.D.A., and O.D.H.A. caused confusion. Dental hygienists were working in private practice with no 'orders' as many dentists didn't feel any requirement to obey a phrase or word in another occupation's statute. The C.D.H.O. held information forums with its members to try and alleviate fears and to explain the legislation as it stood, with varying degrees of success.

The Minister of Health had decided that the issue of the Dental Hygiene proposed amendment would be dealt with internally through the Ministerial route by the Professional Relations Branch and the May 25th consultation date was announced. Dentistry's lobbying techniques and abilities became evident. An example at the R.C.D.S.O. was that there had been a recent change in Council members through an election process. Delay tactics appeared as the R.C.D.S.O. said that the Executive could not meet until May 6, 1994. Thus, the R.C.D.S.O. Council could not make a decision until its meeting in June as this issue required Council discussion, not merely an Executive decision. Of interest to note is that, in preparation for the legislation, the transitional councils of new Colleges were forced to meet timelines and did so successfully. Also, according to statute, the Executive can meet between Council meetings to carry on the business of the Council. So, this researcher suggests that the well-established R.C.D.S.O. could, if it wished, meet the timeline.

To prepare and inform the C.D.H.O. and R.C.D.S.O. about the May consultation/Ministerial process, the P.R.B. convened a meeting on April 14th. At this time, the homogeneity of the professional dominant dentists and the power of the R.C.D.S.O. over dentistry, particularly a small group of public health specialists in the province, became evident. The Public Health dentists' letter (Appendix F) made it appear as though their programs had never been in jeopardy and they were, at the moment, operating comfortably within the 'order' requirements.

It became evident that, although the new legislation was to provide all professionals with "equal status and a public policy forum in which to express their views" (Schwartz, 1989: 4), some professions were more equal than others and their views carried more weight.

The consultation meeting was held on May 25, 1994. At that time, all of the dental organizations expressed opposition in principle to self-initiation by dental hygienists.

The strategies of two of the key dental organizations further illustrated the 'agonisms.' The O.D.A. did not submit its presentation prior to the meeting although there was a submission deadline. The R.C.D.S.O., on the other hand, had prepared a submission, submitted prior to the date, yet on the date, made a statement objecting to the process and requesting the Minister to refer the matter to H.P.R.A.C. (Appendix G).

The May 25th consultation meeting served as a catalyst and brought to light the agonisms; dentistry fighting to maintain the 'status quo' and dental hygiene struggling for change. Although the differences in access to lobbying and decision-making was evident, the fact that dental hygiene had the opportunity to participate in the consultation session indicated an initial stage in the evolution to equality among the professions. This is a direct result of proclamation and signals a change in the social organization of health care delivery.

The P.R.B. of the Ministry of Health is a significant force as it carries recommendations to the Minister, and acts as an official for the Minister.

> There is little in the Parliamentary tradition that allows for direct control of the bureaucracy and if a Minister knows little or cares little about what goes on in his area of responsibility the doctrine of Ministerial responsibility becomes meaningless and renders legislative control well nigh impossible (Weller, 1970).

The present Health Minister and ten others before her, representing all parties, supported the Review and the R.H.P.A. and its inherent principles. However, the attitudes and principles within the Ministry of Health bureaucracies do not necessarily reflect these same principles. The conclusions in the P.R.B. summary of the May 25th consultation meeting appear to show an underlying bias in favour of dentistry (Appendix H, 7 to 8).

Although it was mainly stakeholders, dentistry and dental hygiene, that made presentations to the P.R.B. on May 25th, Steve Gaetz, Health Promoter at the Shout Clinic, also presented, supporting the proposed amendment. The Shout Clinic is a health service for street youth under 25 who number between 4,000 and 12,000. The clinic focuses on direct, comprehensive health care of street youth and attempts to decrease barriers in traditional health agencies. Street youth are a marginalized population. Because of poverty, an unstable lifestyle, and structural constraints within the health care system, street youth suffer the dual handicap of a higher risk of illness and a lesser ability to access services. Recognizing that there was a demonstrable gap in dental services an oral health study was carried out and the results concluded that living on the streets leads to a deterioration of oral health. Aside from the obvious results of untreated dental and gingival disease, there are other consequences such as discomfort and pain resulting from poor oral health. Lower self-esteem is also a consequence of poor oral health, so is unemployment.

> It is an unfortunate truth that appearances do matter when it comes to finding work. Street youth, plagued with decaying teeth, receding gums, and bad breath, are less likely to find work than if they have good oral health. An unsatisfactory appearance, combined with the lowered self-esteem that may result from poor oral health, may thus lower the employment of street youth (Gaetz, 1994).

Another question the study raised was, "Does poor oral hygiene increase the risk of H.I.V. infection for street youth?". A small number, 2.2% of street youth in Toronto are H.I.V. positive as compared to the national average of %.003 (Gaetz, 1994). Because street youth are poor, are marginalized, and an adequate system of publically funded dental services does not exist, they are generally not able to access the treatment they need. Oral health education strategies need to be developed that are appropriate to the culture of street youth and barriers to accessing oral health services must be reduced so that street youth can make use of them (Gaetz, 1994).

> The proposed revision to the Dental Hygiene Act 1991 represents a positive step in increasing access to oral health services by marginalized groups such as street

> youth ... The role of the dental hygienist ... can reduce the barriers associated with health professionals such as dentists ... gingival problems are as serious as tooth decay ... The tools and apparatus of hygienists are very 'portable,' making outreach to the streets, to other agencies, possible (Gaetz, 1994).

Other groups that provided written support for the Dental Hygiene Act amendment were the Canadian Federation of Labour, the Employer Committee on Health Care, the Ontario Association of Non-Profit Homes for Seniors, and the Consumers Association of Canada. The reasons they gave were: order is unnecessary, expensive and a deterrent, especially to low income individuals; 20% of Ontarians don't see dentists because of the cost; the amendment will increase access to preventive dental care; and, consumers should have the option of choosing their oral health services.

Following the consultation, there was an exchange of correspondence between the Director of the P.R.B. and Don Page, Vice President of the C.D.H.O. The Director, Burrows, a pharmacist, outlined the number of Acts by which pharmacy is governed. The Drug and Pharmacies Regulation Act defines prescriber and prescription in subsection 117(1).

> Therefore, the Ministry of Health does not consider the performance of controlled acts under certain conditions, including the prescription of a procedure by one profession and the providing of care or services to the patient/consumer by another profession according to the prescription as being against the principle of self-regulation (Burrows, 1994).

Page, in his response, reiterated his concern that there is no statutory requirement on dentists to provide 'orders,' and:

> 'order' has no precise definition such as that which exists for 'prescription' in the material you have provided. There is, thus, an important qualitative

difference between 'orders' and prescription (Page, 1994).

Although prescription involves other statutory controls, pharmacy's prescriptive authority is not contingent upon medicine's regulations.

For this researcher, it became evident that bureaucrats have a major impact on legislative policy decisions. Although politicians may advance progressive policies, the technologies of the bureaucracies within the government align with other bureaucracies to maintain the 'status quo.' With the Progressive Conservatives being elected to power June 8, 1995, future researchers can observe and analyze the developments in the bureaucracies of the Ministry of Health for consistency or change in patterns.

Gender and Equity

Kazanjian's study (1992) in British Columbia postulated a relationship between professional status and gender stratification. A systematic gender bias was evident. When gender hierarchy is superimposed on health occupations, differential entry barriers and mobility blockages are evident.

Nursing and dental hygiene are two predominately female health occupations. Although they have the commonality of an overseeing dominant profession, medicine and dentistry, their employment circumstances differ dramatically. Nurses, for the most part, are employed and paid by non-profit, publicly funded institutions, not by physicians. Dental hygienists, on the other hand, are employed and paid generally by private practice dentists.

> Those who are in positions of power expect to have their orders obeyed. If they are not obeyed, power ceases to exist. It is within the sphere of power to apply sanctions and thereby defeat resistance and retain obedience (Porter, 1965: 226).

The dominant professions of medicine, dentistry, pharmacy and optometry have had a profound influence on society's health care values. They are all treatment focused and the client is dependent on the practitioner. Over the years, their power has proliferated and it is supported by peer organizations, government, bureaucracies, politicians, and the social élite. It is not surprising that a dominant profession such as dentistry is determined to maintain a position it fought to attain. One can look at medicine to see a brutal battle it fought to claim healing. The changing social organization of healing from females actively participating to the male-dominated, commodity-oriented medical service was systematic and deadly.

> English physicians campaigned through parliament and the courts to remove female healers from practice, asking for laws that would impose fines and imprisonment against women who dared to compete with physicians. The Church, the State, and the medical profession combined forces to hold witch trials to root out the women healers ... Women healers did not really have a chance - the situation was rigged against them. They were judged to be witches if they presumed to treat people without having studied medicine, yet they were not permitted to study in the only curriculum recognized as 'scientific; - the male dominated universities of the time (Gross, 1984: 60).

Since the beginning of human time, fierce battles have arisen over attempts to change values and social organization. In a period of social transition, which presently is evident in changing values in health care, prevailing values such as hierarchical discourse, professional dominance, the medical curative treatment model and bureaucratic hierarchial structures are being called into question. The R.H.P.A. exhibits a shift in the values of health care. Dominant professions such as dentistry are threatened by this shift in values and are fighting for the existing status quo.

> Of course, force may also be used to safeguard the old order which is threatened. The legitimacy of the old order rests on the old values ... (Porter, 1965: 225).

The Ontario College of Family Physicians is also mounting a challenge against the province's plan to introduce nurse practitioners, using similar arguments as dentistry used with regards to the proposed Dental Hygiene Act amendment. These arguments are contained in statements like the following, "the Minister of Health should refer a matter regarding changes to the R.H.P.A. to the advisory council," and, "it would be dangerous to give people who are not thoroughly trained in diagnostic techniques the level of responsibility proposed by the province" (Coutts, 1995).

Midwifery is a recognized profession in the R.H.P.A. Midwifery is an example of an ancient female healing caring role that was systematically destroyed.

> A determined minority of medical men over several hundred years was able to organize itself, inform the public of its point of view, and use education, licensing and monopolistic power to impose their view on the public. At the same time, they were able to restrict the activities of women healers and midwives who had provided health and birthing services for millennia. If these developments had served the interests of the public for better treatment, then it would not be the good example it is of the use of power and legal structure to enhance the private interests of professionals (Gross, 1984: 59).

Here is an example of how one profession, medicine, grew at the expense of another, midwifery. The male physicians had access to the levers of powers, the universities and the courts. Access to the influential institutions of society is still not equal Power differentials are evident between different professional groups, particularly along gender lines.

In June 1993, the C.D.H.O. wrote to H.P.R.A.C., stating the need to offset gender bias in the new R.H.P.A. The point was made that five of the female dominated professions were subject to control by members of the primarily male professions through the word 'order.' With regards to the social organization of mouth care, denturism, a primarily male profession which closely parallels dental hygiene in terms of education, training and patient/client risk, is treated differently than dental hygiene in the legislation. Denturism is not subject to the restrictive word 'order' requirement so that access to that profession's services is not controlled by the regulatory body of another profession.

In an attempt to find a mutually acceptable interpretation of the word 'order,' the Professional Relations Branch, on the direction of the Minister of Health, convened a meeting on November 10, 1993. Representatives of the R.C.D.S.O., C.D.H.O., and the P.R.B. attended. The government officials stated at the outset that the R.C.D.S.O. would not be allowed to make any unilateral decisions, nor make self-interested regulations. The C.D.H.O. put its concerns and positions on the table, reiterating the importance of one standard of dental hygiene practice consistent throughout practice settings; and, the gender bias issue. A key Ministry official, in summarizing the meeting, said as one of his comments that the "gender bias issue was bunk." He said this with some emotion which is unusual as "impersonally, [they] detached officials attempt to maintain an 'efficient' social distance from clients by the 'neutral' application of explicit rules and regulations" (Nelsen, 1991: 206). The gender bias issue was definitely a 'trigger' which started some significant correspondence. Page, the one male attendee from C.D.H.O. and an engineer by occupation, was distressed by the government official's reaction and he communicated his concerns. The Director of the P.R.B. stated that the government remains committed to its equity policies and that the R.H.P.A. and the 21 profession specific acts contribute significantly towards that agenda.

> The Schwartz Review (H.P.L.R.) identified the fact that the existing hierarchy of professional regulation in Ontario was undesirable and that there was evidence of gender bias vis-a-vis an 'old boys' network that had historically influenced policy. Both the previous and current governments accepted this argument as part of the reason why the current outmoded system of professional regulation in Ontario needs to be replaced (Burrows, 1993b: 3).

He goes on to acknowledge that gender bias may be lingering in the legislation.

> ... it would be wrong to conclude that there is no gender bias in the regulation of the health professions. The Government and the Health Professions Legislative Review openly acknowledged that this was the case in the past. Similarly, the Ministry has never taken the position that R.H.P.A. is perfect or that it would accomplish all desired goals at the outset. Rather, our position is that it is simply a lot better than the current system and it offers flexibility so it can be more readily adapted to meet future needs (Burrows, 1993b).

After providing a fairly lengthy discourse about pharmacy and other professions relying on prescriptions, the letter continues:

> You may have hit upon a reason for the R.H.P.A. approach to 'orders' as it relates to the profession of dental hygiene where you mentioned the effectiveness of various lobbies during the legislative process ... it may well be that some professions were more effective in putting their self-interest before the legislators and that this somehow impacted upon the final content of the legislation (Burrows, 1993b: 7).

The lobbying pressure of the Ontario Dental Association to maintain control of dental hygiene is evident in correspondence from the Executive Director of the O.D.A. to the Health Professions Advisory Council in 1993:

> ... dental hygienists would continue to be required to perform their controlled acts in an established relationship with dentists because the procedures they performed were part of the controlled acts limited to dentistry and the procedures were of potential harm to the patients (Gillies, 1993).

In the summary of the issues regarding the proposed dental hygiene amendment, the P.R.B. asks:

> Is there a bona fide gender issue?
>
> While the dentistry profession is graduating increasing numbers of women from its schools, the ratio of male dentists to female dentists is still high. The ratio of female dental hygienists to male dental hygienists is also very high.
>
> To the extent that this involves predominantly male dentists 'ordering' predominantly female dental hygienists, there is, in its simplest terms, a gender issue. The regulatory issue remains, however, as to whether this has any direct bearing on the issue of 'order.' There also exists a number of male dominated professions which are 'ordered' by other male dominated professions (P.R.B., 1994: 7) (Appendix H).

Gender is a variable in most of the issues; status quo, self-governance, training, and assessment. A double standard is supported by the male dominant professions and the continuance of 'orders.'

Dentistry's experienced and effective lobby has also resulted in pressures being placed upon many dental hygienists in the work force. Presently, dental hygienists' primary site of employment is the private practice dental office. In this confined space, dental hygienists are estranged from their colleagues and do not have the same opportunities for internalizing professional attitudes. This lack of "work collective" has been seized upon by dentistry to prevent homogeneity of dental hygiene.

One of the dental hygienists who was accompanied by her dentist employer attended the May 25th P.R.B. session to speak against C.D.H.O.'s proposed amendment. She refuted the gender bias position.

> Historically, dentistry may have been primarily a male dominated profession but this is the 1990's and now dental faculties graduate dentists in Canada on a 50:50 ratio of male to female. If any gender bias exists, it is in the dental hygiene procession which boasts over 90% of its graduates are female. I want to make it clear that dental hygienists around the province work in a team environment in the delivery of dental services, where each member of the dental team is respected and supported by the other members of the team without gender bias being an issue (Rideout, 1994).

Working within the established private practice of dentistry, the dental hygienist, as Smith might say, enters a social relation that organizes her relations with others into determinate forms (Smith, 1990: 78). Often it is stated dental hygienists are part of a team. However, unlike a football team, everyone in the office does not wear the same uniform and the hygienist runs into trouble when she plays out of position.

Although dentistry emphatically states that gender bias is not an issue, it was interesting to note the gender balance of dentistry's specialty presenters May 25th. The 1990 Statistics Canada indicate that 19% of dentistry is female. According to the R.C.D.S.O. 1993 listings, there were 242 orthodontists in Ontario (16 female), 83 paedodentists (13 female), 132 periodontists (10 female), 35 public health dentists (4 female), for an overall average of 10% female. Although more females are entering dental schools, about 40% according to Statistics Canada, the profession and, particularly the specialities, still are predominantly male. However, on May 25th, the majority of the dental specialists presenters were female. These women were not the elected official spokespersons for their respective organizations, although the female paedodontist was the secretary treasurer of her organization. Unwittingly, perhaps, these women were used by the men to visibly dispute the gender bias claim.

During the H.P.R.A.C. process in 1995, the Ontario Nurses Association referred to the gender issue.

> Our experience as a profession which is 98% women who have worked primarily under the direction of male doctors leads us to believe that there is very definitely a gender issue involved. There is something more than public protection at stake when dentists insist that women need individual orders to carry out procedures in which they have been specially trained ... we can only think that when dental hygienists are specially trained in periodontal cleaning there must be a bona fide gender issue as well as economic self-interest involved in the effort of some dentists to prevent dental hygienists from self-initiating this procedure (Cornelius, 1995).

The College of Nurses, the nurses' governing body, stated:

> C.N.O. agrees with the H.P.R.A.C. statement that gender bias must not restrict the scope of practice or self-initiation of any profession ... (Risk, 1995).

George Brown College in Toronto is unique in that it offers dental hygiene as well as the only denturist program in Ontario. Many of the didactic courses are shared with dental hygiene students. The fact that dental hygienists must have an 'order' from a registered member of the R.C.D.S.O. is, according to the Dean of Health Sciences at George Brown College:

> ... an unfair requirement for dental hygienists given that the educational courses dealing with assessment, planning and implementation of oral health care are identical. One group has been absolved of requiring this order but the other group requires it despite the same educational background (Mulder, 1995).

Denturists' procedures present as much risk of harm to clients as dental hygienists' procedures of scaling, root planing and curetting. Education and training requirements for the two professions are similar. However, a major difference is that denturists are predominantly male while dental hygienists are predominantly female. Denturists specialize in making oral prosthetics to replace extracted or missing teeth. The new legislation enabled this group to provide partial dentures, a procedure which entails risk of harm, to patients without an 'order' or prescription from a dentist. The dentists lost the partial denture 'battle' during the Review process. However, prior to this legislation, the public could choose to access denturists or dentists for full dentures in separate, independent practices. Thus, the control that dentistry had/has over dental hygiene's employment and economic environment does not exist between dentistry and denturism. Also, periodontal treatment (scaling) done by the dental hygienist is the treatment most claimed through dental insurance benefit plans. More people are keeping their teeth for life through regular maintenance. Thus, if the public was able to access these oral health services directly, or if the insurance companies decided to reimburse dental hygienists directly, or if corporations decided to employ dental hygienists to provide the preventive oral health services, dentistry would suffer financially.

In H.P.R.A.C.'s request for information, they state that one equality/equity issue identified in the course of the process leading up to the referral was gender.

> The first issue relates to gender and the concern that a traditionally male dominated profession, dentistry, controls the authorized acts of a traditionally female dominated profession, dental hygiene. Issues relating to gender and gender equality are of serious concern to the Council. Gender can and does affect what appears to be neutral practices, such as perceptions of what a female dominated profession is capable of doing. Practitioners should have the opportunity to practice their profession without impediment, to the full extent that their training and skill permits. Gender bias must not restrict the scope of practice of self-initiation of controlled acts of any profession. The right to self-initiate must be based solely on the skill, competence, and training of a profession (Jefferson, 1995: 13).

Dentistry's response to this area was of interest to this researcher. The R.C.D.S.O. notes that inequalities do exist for women in society and that these inequalities have roots in the very structure of our society which are vestiges of extremely hierarchical and pyramidal societies in which confrontation and mistrust prevail (R.C.D.S.O., 1995). The submission goes on to describe the fact that more females are being accepted into dental schools. The R.C.D.S.O. appears to make the assumption that women take dental hygiene because they cannot access dentistry easily:

> Thus, access to dental education by females has become increasingly less of a problem so that women who now choose positions of greater responsibility can access the education that will open the door to this responsibility. The real issue at hand is not hygienists have been banned from doing duties that they are capable of, but they have chosen for whatever reason, not to avail themselves of an education which requires a greater number of years and a greater financial sacrifice than does the dental hygiene education ... The decision to not access this education is not the fault of the dental community and the public should not be put at risk to promote the professionalism and self-esteem of the dental hygiene community (R.C.D.S.O., 1995).

The R.C.D.S.O. submission ignores the fact that dental hygiene is preventive-focused, client interactive and differs from dentistry's culture of patient dependency on treatment. The power relations and inherent resistances are evident as the 'tug of war' continues over the provision of preventive oral health services. The outcome may be the possibility of new power relations and a new domain of knowledge.

CHAPTER 6:
SUMMARY OF FINDINGS

Has the Regulated Health Professions Act changed the social organization of health care delivery? As this research proceeded, it became evident that this question has two distinctive parts; one involves the providers and the other involves the consumers. There is definitely a change with regards to the providers. The R.H.P.A. has legitimized and recognized many health care occupations which were considered previously as subordinate in the hierarchy of health care. However, further research can determine whether or not the new regulatory system changes the social organization of health care delivery for consumers so their choice of providers and entry to the system can be actualized.

The following summarizes the findings within the themes previously discussed. This research confirms that this new multi-health occupational legislation is a site of power relations. Power is exercised only when subjects are free, able to resist, and not oppressed. Freed from direct regulation by dominant professions, health occupations such as dental hygiene are faced with a field of possibilities. These new independently regulated Colleges are enabled by legislation to set their own standards of practice, course curricula, entry and re-entry requirements.

In the case of dental hygiene, it appears, on one hand, that the R.H.P.A. has freed dental hygiene from regulation by dentists. New opportunities could be created for dental hygienists and other regulated health care providers to form new health care partnerships if the established professions permit, and the public advocates for more choices. Also, due to various pressures in the private dental practice environment, economic and political, dental hygienists will be seeking new areas to practice. One would expect that these potential changes in practice location will increase consumers' choice for accessing preventive oral health care.

This study has shown that the legislation has resulted in resistances. These resistances are significant and dental hygiene is a catalyst in the realigning of professional forces. The struggle of the newly regulated health occupation, dental hygiene, to attain independence and gain freedom from dentistry's regulation puts into question "the evolution of a more flexible, rational and cost efficient health care system" (Schwartz, 1989: 4). However, the legislation has enabled new power relations and this researcher's expectation is that shifts in power will occur, resulting in more choices for providers and consumers.

As shown, discourse can perpetuate traditional power/ knowledge. The myth has existed that professions have certain knowledge. Dentistry continues to assert that, in contrast to dental hygiene, dentistry is systematically applying scientifically based and certified knowledge and is best qualified to determine when oral health care should be initiated.

> However, during the last thirty years, the findings of the philosophy and sociology of science, convincingly demonstrate that scientific knowledge is not, and cannot be, objective in the required sense (Brante, 1988: 131).

"There is no logical connection between general scientific theories and professional practice" (Brante, 1988: 131).

> ... studies show that experts, when confronted with some problem, frequently reach diametrically opposed conclusions even though they have access to the same facts ... The most possible interpretation of such conflicts is, again, that general knowledge does not offer unambiguous answers, and that, therefore, other variables are of influence when professionals 'make up their minds' and suggest a particular route of action. Those other variables seem to be of a social nature, such as political affiliation, ideological conviction, or occupational position (Brante, 1988: 132).

It is likely that the boundaries between health care professions will continue to change as educational and informational systems change, so these providers can be effective change agents in health care delivery.

Bureaucrats occupy key positions that do not rest on legal authority. "They are pragmatic nihilists to which nothing is sacred ... They develop a new amorality ..." (Brante, 1988: 123).

The dental hygiene experience with the bureaucracy is significant. The Professional Relations Branch, although speaking political correctness, appears to this researcher to have an underlying bias towards the 'status quo' which was reflected in the P.R.B.'s summary (Appendix H: 7-8).

As a participant observer, experience revealed the influence and control exercised by the bureaucratic administration. The information passed on to the politicians is affected greatly by the technology of the bureaucracy. Does the technocratic myth justify deviations from democratic principles? Reason is what technique and humanity have in common. Technique rationalized became an instrument of human reason in society. Bureaucracy is one such instrument that gave greater freedom to some, however, this most rational of systems also sustains social inequities (Ellul, 1990: 160). Although the abstracted generalizing language of bureaucratic and professional organization is capable of incorporating the economic and social diversities of a population, this potential to serve the larger societal needs of equity, empowerment and inclusive participation in health care is not always actualized.

During this research, the powers, the attitudes and the importance of the unwritten rules of the instrument of bureaucracy became evident. What also became evident was that there are many pathologies in the rationalized bureaucratic model. The high degree of social organization through bureaucratic tools leads to focusing on people as means rather than ends. The rules and procedures of bureaucracy become ends in themselves. Because of the hierarchy within the bureaucracy, it is difficult to effect changes. The 'status quo' attitudes of some key bureaucrats pervade the system and thus limit change as these attitudes become reflected in documentation provided to politicians. This documentation eventually becomes legislation.

Since many bureaucrats are economically secure in their positions and some are unmotivated by principles of social justice, they may resist requests unless these requests are accompanied by the intervention of an influential person or organization. Political or economic privilege can also interfere with impartial functioning by the rules.

> Bureaucratic frameworks are possible ... for ensuring a modicum of accountability and control, but within these

> frameworks there must be heavy reliance on the regulatory processes, carried out by the participants themselves. There is where the system is most vulnerable ... the framework can be used by the participants to protect and advance their own ends at the expense of the intent of policy ... (Freidson, 1978: 982).

Competing interests now are mediated by the Health Professions Regulatory Advisory Council which is specially constituted. It is composed of Lieutenant Governor in Council appointees drawn from outside the civil service, the government and health professions, for the purpose of advising the Minister on matters of policy and possessing no executive powers of its own. Other established 'arms length' bodies such as the Ontario Council of Health and the Ontario Council of University Affairs have been fairly successful in 'buffering' between government on one hand and organizations with strong traditions of autonomy on the other. Such a council has a better chance of gaining trust from competing interests than a bureaucratic agency. As an 'arms length' body:

> It would bring a balance of perspectives to bear on the issues of professional policy, and, as opposed to a bureaucratic agency, it would have the major advantage of publicly reporting. Hence, it could provide for informal and balanced discussion of professional policy in context broader than that afforded either by bureaucratic agencies or, at least currently, by professional governing bodies (Trebilcock, 1979: 228).

An extremely important part of the <u>R.H.P.A.</u> is the participation of health care consumers on the regulatory bodies. As just under 50% of the Councils are made up of these public members, appointments and re-appointments hopefully will be done with integrity and based on some criteria. Unfortunately, as the Colleges held their first elections after proclamation of the

R.H.P.A., serious questions began to surface about the integrity of the public appointments process. This researcher heard from personal conversations that many colleges, including the C.D.H.O., experienced peculiar appointment patterns. Page, who had been Vice President of the College, Chair of Regulations, and Coordinator of the Dental Hygiene Act Amendment, was not reappointed. One returned public member was appointed for a two year term, the others returning from the Transitional Council were only appointed for one year. When asked for the rationale, the only response the Public Appointments Secretariat gave was "It's the Minister's prerogative." It certainly is the perception of some that the public appointment recommendations to the Minister reflected a particular bureaucratic agenda.

It has also become evident to this researcher that gender inequities persist in both formal and informal bureaucratic organizations. Although women such as the dental specialists and the Deputy Minister of Health may be made visible within these structures, the experiences of typical women's lives "constitute a submerged voice within the overall discourse of bureaucratic society" (Ferguson, 1984: x). One example is the inclusion of the word 'order' in some profession specific Acts. The word 'order' in the R.H.P.A. is only applied to professions that are female dominated - dental hygienists, medical laboratory technologists, radiology technicians, and nurses. The dominant professions did not include these groups in their decision making process regarding 'order.' Truly, self-regulating professions control their own standards of practice through enforcement of their own regulations. They are not subject to control by standards of practice of 'ordering' professions. Also, as previously discussed, the word 'order' is not defined in Statute. It is a word that is traditionally associated with military hierarchy and perhaps does not belong in evolutionary new health legislation intended to be less traditional and less hierarchical.

The research shows that gender inequities are also perpetuated in discourse, the professions, and the various bureaucratic institutions. The professional schools such as dentistry constitute an area of social interaction which makes for social homogeneity of the élite, still predominantly male. Their training prepares them to establish occupational hierarchy in their private practices. As discussed previously, tasks associated with the ideology of domesticity, such as cleaning and caring, were assigned to the dental hygienist curriculum which was restricted initially to women. As previously contrasted, the primarily male health occupation of denturism, which has comparable education/training requirements and risk of harm to patients, practices independently.

Support was received from other female dominated professions who have experienced similar oppression. The following was part of the Ontario Nurses Association submission.

> We are not impressed by the argument that if general dentists cannot always tell the difference between dangerous and non-dangerous conditions, then surely dental hygienists are not competent to do so. We certainly agree that there are subtle conditions which dentists may miss because health care professionals do not have perfect knowledge - in fact, no one has perfect knowledge. However, to suggest that specialists or

further tests which they may order are always able to detect conditions which general dentists and dental hygienists cannot is surely arrogant (Cornelius, 1995).

Thus, the word 'order' issue may have provided an opportunity for some of the female professions to affiliate, to collaborate and to state through political and legal means, what it is they view as deterrents to better public health. Dental hygiene has gained experience in the political process, lobbying techniques and it has formed new alliances. For instance, during the H.P.R.A.C. exercise, dental hygiene educators across Ontario worked together with C.D.H.O. to address the questions pertaining specifically to course curricula. Knowledge and experience was drawn upon from dental hygienists throughout North America to answer other questions. Also, material from many academic researchers support the C.D.H.O. position of choice and access.

"Inefficient use of health manpower [sic] is not just economically wasteful, it is also inequitable" (Manga and Campbell, 1994: 7). Dental hygienists have not been efficiently used in the community to promote optimal oral health and thus contribute to the total health of the public.

Prior to the R.H.P.A., dominant professions had a kind of cartel, more deeply entrenched than any guild and more international than any labour union. In common with guilds and unions, they had a monopoly over the work they did which enabled them to preclude the consumer from shopping elsewhere. The dominant professions of medicine, dentistry, optometry, and pharmacy held licenses and had legal endorsement through the Health

Disciplines Act and regulation to control human health needs. This particular type of occupational control is not the inherent nature of particular health occupations, rather it is a continuing strategical exclusion (Illich, 1978: 342). The public acceptance of such dominant professions is essentially a political event. Monopolization of opportunities is exemplified by dentistry as it exerts its power to exclude dental hygiene so it can continue to maximize its own rewards and privileges. Although addressing gender equity, cost containment, alternative health care delivery models, rural, northern and inter-city access are politically correct principles, the dominant professions presently have the motivation, experience, political will, and money to resist the political current.

The word 'order' that came with the Dental Hygiene Act is an effective deterrent to the evolution of the care of the mouth because it imposes a practical restriction on dental hygienists practicing in settings other than with dentists, thus restricting consumers' access to preventive oral health care. As this is being written, H.P.R.A.C. has not made its recommendation to the Minister of Health. So, the ability of consumers to choose their point of entry for oral health care remains in dentistry's control. Thus, it remains to be seen whether, in the case of oral health:

> the new scope of practice system will provide better public protection while permitting more efficient and cost-effective delivery of health care services (Schwartz, 1989: 4).

Since dentistry is mainly fee-for-service, practiced in the private sector, public policy in dental resource supply or service organization has been virtually non-existent. Also, the fee-for-service model perpetuates the medical treatment model and discourages prevention. However, the resistance of dental hygiene to the word 'order' has brought public and political attention to the private practice of dentistry and the present limits to oral health delivery. Further research can determine whether regulatory policies of the dominant profession are able to perpetuate the medical treatment model and the occupational hierarchy.

Space, according to Foucault, as previously stated, is a web of social power; so, reorganization of space is always a reorganization through which social power is expressed. This reorganization is evident as hospitals are restructured and long-term care and multi-service agencies are introduced. (As this was being written, the new government, under the Progressive Conservatives, announced that the multi-service agencies will not be introduced.) As this reorganization of space takes place, the regulated health professions hopefully will be able to deliver their health care in alternate practice settings. Change in the social organization of health care delivery for the consumer means breaking down existing hierarchical structures in discourse, in power/knowledge, and in bureaucracies. Workforce reform is required that encourages collaborative, effective working relationships among health care providers. New inter-disciplinary alliances need to be formed. A flexible cost-effective health care system should respect consumers. Regulated health care providers need to inform consumers accurately about the types of services that are available. When consumers have knowledge, they will be empowered to make informed and independent decisions for their choice of health care provider. Under the present system, clients have limited knowledge, so their needs frequently are determined by the dominant profession's preferences.

Studying the emergence of dental hygiene as an independently regulated health profession, utilizing Foucault's approach, provided an opportunity to observe, review and analyze the complex factors that affect changes in the delivery of health care. Some conclusions have been derived.

Conclusions

This particular research, originating from the standpoint of a rather ordinary and mundance practice, oral health delivery, was initiated to determine whether or not new discourse, in the form of new health legislation in Ontario, results in a social reorganization of health care delivery.

Established traditions are embedded in new legislation. The word 'order' is a prime example. It is only a word; one might think could be changed easily. However, that word is clothed with professional dominance, the technologies of bureaucracy, gender bias, and élitism of those professing to hold specialized knowledge. It appears that the word 'order,' which is in five of the twenty-one profession specific Acts (Medical Laboratory Technologists, Respiratory Technologists, Radiological Technicians, Dental Hygiene, and Nursing which includes self-initiation) and not the R.H.P.A. itself, perpetuates the old regime. The retention of the word 'order' may maintain the control of emerging professions by the dominant male professions. As a formal rational regimen, 'order' presently appears to constrain opportunity for generally autonomous conduct and greater access by consumers. Thus, the R.H.P.A. presently maintains the hierarchical social organization or relations among professions in the organization of health care delivery in the community. "The relationships of super and subordination in these relations both recapitulate and perpetuate historically established gender relationships" (Smith, 1990: 99).

> There is ample evidence to support the view point that dominant groups invoke their powers to exclude competing groups and that exclusionary tactics are intimately connected with powers legitimized by the state (Burtch, 1988: 322).

However, the resistance of dental hygiene to dentistry's continuing subordination is one example of how the new regulatory system is resulting in a social reorganization of health care delivery for the regulated providers. Also, the public consultations and forums are increasing the consumers' and professionals' awareness, thus challenging existing perceptions and beliefs about the institutions and practices of health care delivery. As public awareness is heightened, consumers will pressure politicians, perhaps to initiate changes that will alter the present delivery systems, thus enabling consumers to make informed choices regarding their health care providers.

As stated previously, truth and knowledge are generated from power situations.

> The mouth and teeth became the focus of a distinct discipline that was founded in the mid-nineteenth century

> ... The mouth and teeth seen by the dentist today is a very different one to that seen by the dentist 50 to 100 years ago. It is not a fixed, pre-existent, static entity. The word mouth has a different meaning in differential, spacial and temporal locations (Nettleton, 1992: 126).

Studying a rather mundane and familiar, but relatively unexplored, arena, the care of the mouth, power relations are revealed which are rooted in the system of social networks. Foucault reminds us that there is a completely different way of looking at and thinking about things, including oral health. It is possible that the way the physical and social world is currently organized with regards to oral health care specifically, and health care in general, and how it is thought about and perceived, could be so different in the future that it would be unrecognizable from this present standpoint.

Limitations of the Study

This study does not address the economic effects of the new legislation. Many anticipated that change in the social organization of health care delivery would result in economic changes. Historically, dentistry, like medicine, has sought and achieved current organization and reimbursement methods through negotiation with government and insurance companies that entrenched their monopoly position (Manga and Campbell, 1994: 79). However, insurance companies are seeking ways to reduce their costs and unions are striving to reduce the cost of their benefit packages. Presently, the procedures provided by dental hygienists in private dental practices are a major expenditure for third party payers.

Thus, alternative funding arrangements and practice modalities may be incentives to organizational change.

> The reduced costs and greater accessibility to hygienists' services could go a long way to improve the oral health of the public and thus to reduce the need and demand for more complex and costlier care required by dentists (Manga and Campbell, 1994: 27).

Change in reimbursement mechanisms could hasten a reorganization of health care delivery, perhaps to the advantage of consumers. Also, permitting regulated practitioners to choose alternate practice settings might encourage competition and, thus, increase consumers' ability to access more affordable options.

Future Research

Analysis of qualitative data is a dimension of research, not a final stage. Thus, there is always future research. The R.H.P.A. is a womb for researchers from many disciplines; law, philosophy, political science, economy and sociology. Future researchers can determine whether the R.H.P.A. permitted evolutionary development. The intent was that the R.H.P.A. would provide a flexible statutory framework which would allow the regulated professions to evolve and to adapt to societal and regulatory changes and requirements.

The Review stated:

> ... the structure of the legislation and the resultant ease with which provisions can be amended will maintain the system's relevance and usefulness during the years of change that lie ahead for the health care system (Schwartz, 1989: 17).

Recommendations sent to the Minister of Health from H.P.R.A.C. regarding dental hygiene and nurse practitioners in the Spring of

1995 and the subsequent action by the Ministry will indicate the relevance of the above statement. It was intended that there be scope for evolution in the roles played by individual professions and flexibility in how individual professionals could be utilized so that the system operates with maximum efficiency. Future studies will determine whether more accessible entry points are available to a choice of regulated health care providers by consumers.

The P.R.B. summary addressed costs. "Without an independent cost-benefit analysis, it is difficult to ascertain whether any real savings accrue from such an amendment" (P.R.B., 1994: 5). This statement overlooks consumer choice. Would it not be better for consumers to have an open market, regardless of cost? Future research may determine the cost benefit.

Will public perception of health care change so that there is a paradigm shift from treatment to prevention? Public awareness is necessary if consumers are to become less dependent on the medical curative treatment model and the dominant professions.

Will there be more accountability on the part of regulated health care providers? There needs to be informed dialogue and difficult debate between the professions and the public about what and how quality care can be attained and maintained. Increasing the professional/public collaboration is important if the real interest of the public is to be served. Certainly, the intent of the R.H.P.A. is to serve the public interest. This will require collaboration of the public and providers together to ensure quality care, safe and ethical practice in environments that encourage rather than inhibit such practice (Donner, 1995).

For researchers interested in organizational studies, implementation of the R.H.P.A. provides a wealth of data. The bureaucracies of the regulatory bodies and the government can be observed for their inclusiveness.

> To be representative, a bureaucracy must contain a reasonable cross-section of the population in terms of occupation, social class, ethnic groups ... and those working in it must share the values and attitudes of the society as a whole. When bureaucracies are representative of the various social groups composing the society, they presumably have a sufficient feel for the social fabric to be able to give socially significant or 'effective' advise to political leaders (Porter, 1965: 449).

Traditional bureaucracies are hierarchical and militaristic. The established regulatory bodies have governed in this model. How can self-governing bodies which are supposedly committed to autonomy and community interaction continue to govern their registrants using a hierarchical paradigm? Will the increased number of female professionals influence a change in governance? Or, will females in these structures merely adapt to the existing hierarchies and, thus, perpetuate the dominance model?

It will be exciting to watch and see if the gender divisions of labour are re-negotiated. Will there be a breakdown of the monopoly and collegiality of the dominant professions in favour of new partnerships and new economic arrangements? There is much to watch and study as the changes take place in health care delivery.

Contributions of the Study

The intent of this study is to contribute to the sociological body of knowledge in an arena that has received little attention. Much research has been done in the area of health care and costs generally. However, very few studies have been carried out regarding oral health care or the social structure and professional organization of dentistry and dental hygiene. Dickoff and James (1988) state that despite the increasing number of dentists being trained and graduated, "there seems to be a deficit of information about matters pertaining to teeth and mouth. Sex education has been more thorough apparently." It is unfortunate that the mouth, the gateway to the body, a window on health and disease, has been overlooked. Although Stamm (1981) has done an overview of Canadian dental care delivery systems and Croucher (1988) outlines the dentists' response to the Saskatchewan government's dental care plan for children, very little data exist about the prevalence, incidence and distribution of dental disease in Canada. Public policy in dental resources supply or service organization has been virtually non-existent (Kazanjian, 1992: 15).

This author anticipates an indirect practical application of this research. It is hoped that dental hygiene human resources and non-traditional work settings can be linked to provide the public with increased choices of providers and access to the oral health care system. In addition to expanding the body of knowledge in the area of health care delivery, this researcher is hopeful others will continue the study of this health legislation and the practices surrounding the mouth.

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APPENDICES

A - The Regulated Professions

B - The Word 'Order' (Military Personal Notes from J.D. McIntosh, World War II)

C - Proposed Amendment

D - Controlled Acts (R.H.P.A.)

E - Internal Memo, Hicks to Leake Main Tipping

F - Hicks and Main, Letter to Citrome

G - R.C.D.S.O. Statement to P.R.B. (May 25, 1994)

H - P.R.B. Conclusion to Summary of May 25, 1994, Meeting

I - H.P.R.A.C. Referral, Page's Chronological Summary

APPENDIX A:
The Regulated Professions

- Audiologists
- Chiropodists
- Chiropractors
- Dental Hygienists
- Dentists
- Denture Therapists
- Dental Technologists
- Dieticians
- Massage Therapists
- Medical Radiological Technicians
- Medical Laboratory Technologists
- Midwives
- Registered Nurses &
  Registered Practical Nurses
- Occupational Therapists
- Opticians
- Optometrists
- Pharmacists
- Physicians and Surgeons
- Physiotherapists
- Psychologists
- Respiratory Technologists
- Speech & Language Pathologists

Commandments [illegible] Comrades

1. The order [illegible] [illegible] must be very deepest [illegible] since nothing is impossible in the execution of an order recieved.

2. Bring understanding to your comrade in all things. Give him your help, your advice and your support always, and above all your leadership, particularly if it is a case of dealing with one young in the fight and inexperienced.

3. If you stand at a post in front of the enemy be fully responsible for the life of your comrades. The smallest carelessness costs many men's lives and precious blood may be given away through your neglect of duty. That is a crime against your race.

4. Every soldier is responsible for the carry-through of an ~~[illegible]~~ march. Always halt with open eyes, equally whether you are marching in a column, a driver or a passenger.

5. Conceal yourself immediately. Think about it, since you betray not yourself but your comrades beside you.

6. He who digs, saves his life. Constantly improve your ~~[illegible]~~ position against fire and sight.

7. Think always in the attack of your comrades on the left and right of you.

From J. D. McIntosh's personal notes from World War II

Appendix B

<u>Amendment to Section 5, Dental Hygiene Act, 1991</u>

The current wording of section 5(1) is as follows:

> 5. (1) A member shall not perform a procedure under the authority of section 4 unless the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario.

The Transitional College of Dental Hygienists of Ontario proposes that section 5 be amended as follows:

> **5. (1) A member shall not perform a procedure under the authority of section 4. 1. unless:**
>
> **(a) the performance of the procedure by the member is permitted by the regulations and the member performs the procedure in accordance with the regulations; or**
>
> **(b) the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.**
>
> **(1a) A member shall not perform a procedure under the authority of section 4. 2. unless the procedure is ordered by a person who is authorized by the Dentistry Act, 1991.**
>
> **(2) In addition to the grounds ....**

<u>Rationale</u>

The authorized act of scaling teeth and root planing can properly be done by dental hygienists independently in definable circumstances. In other circumstances, the patient must first be seen by a dentist. In this regard, the two controlled acts authorized to dental hygiene can be distinguished from each other, and the independent performance of scaling can be analogized to certain Nursing acts.

Accordingly, we have modeled the proposed amendment on the Nursing Act, 1991, adopting the approach to setting out the circumstances in which the act can be independently performed in the regulations, and referring to persons authorized by the Dental Act, rather than members of the RCDS.

dh-amend.doc

APPENDIX D:
Controlled Acts, R.H.P.A.

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,

   i. beyond the external ear canal,
   ii. beyond the point in the nasal passage where they normally arrow,
   iii. beyond the larynx,
   iv. beyond the opening of the urethra,
   v. beyond the labia majora,
   vi. beyond the anal verge, or
   vii. into an artificial opening into the body.

7. Applying, or ordering the application of a form of energy prescribed by a the regulations under the Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in clause 113 (1)(d) of the Drug and Pharmacies Regulation Act, or supervising the part of pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

E

DENTAL SERVICES

SIMCOE COUNTY DISTRICT HEALTH UNIT

To: Drs. Leake, Main, Tipping

From: T. Hicks

Subject: <u>RHPA regulations</u>

Date: November 15, 1993

I had quite a session on Wednesday last, with Ella Schwartz (MoH) and then a conference call with Roger Ellis, Minna Stein and Don McFarlane.

It was over the proposed regulations and, particularly, the question of reviewing a medical history prior to initiating treatment and the issue of "orders".

(1) I think Ella was able to follow our rationale about reviewing medical histories. The point being that there did not appear to be any further benefit to the public health by requiring a dentist (public health or private) to review a "clear" medical history, taken by a qualified health professional.

I'm not so sure that this was greeted with enthusiasm by the RCDS folks. Firstly they thought that our concerns had been resolved and that the College had made a major concession following the presentation by Pat and I at the regulation meeting. (By the way, our response was pretty thin since we had been advised that there would be no opportunity to speak).

I reminded them that we had asked for a rationale supporting their contention that a review was necessary for a clear history and that we had not received a reply. Hence, our ongoing concern over this issue.

Finally, in exasperation, I suspect, Roger asked me to write up the regulations to suit the public health issue. I took a shot at this, faxed it to him, and the enclosed is a copy of that effort.

(2) "Orders" seem to mean different things to people. The RCDS appears to mean a specific order for each patient for each course of treatment. They don't seem to understand (or perhaps have rejected) the notion of "standing orders". The latter, of course, provides direction to staff covering most situations which may arise and outlines an appropriate course of action for cases which do not follow the usual pattern.

I made the point that standing orders should be equally available to private dentists ~~as to~~ public health dentists.

Beyond this we had a discussion -at least with Minna- about the provision of hygiene services to medically compromised individuals, nursing home residents in particular. Her opinion is that, as dentists, we have the responsibility to review these complicated medical histories and to decide both on appropriate therapy and proper prophylactic coverage.

I contended that these complex histories require collaboration between the dental service and the patient's physician. Although I have the responsibility to decide (or give direction as to the appropriate dental therapy) it was very much the physician's decision whether or not the patient:

1) should undergo the proposed therapy
2) requires prophylactic coverage prior to therapy

Reading the confusion about the latter with respect to prophylactic coverage for hip replacements, heart murmurs, etc., I would be loathe to make this determination without medical advice. I did state that it was my responsibility to indicate to the physician the possible sequelae of the procedures (ie. scaling and cleaning may cause some gingival bleeding and the possibility of bacteraemia).

Apart from this, we need to decide, as a society, our position on the use of office staff trained by the private dentist to provide the "assigned acts". I personally have a real problem with this. Who decides if these people are truly qualified or trained for these activities? If someone doesn't have this responsibility, there will be no standards at all! In that case, why mention these activities in the legislation at all?

We need to know (quickly) what the RCDSO's final position is and if it is contrary to our policy, take appropriate action at the next level of the review. Ella suggested a letter to:

The Minister of Health

Ms. Christie Jefferson
Chair, Health Profession Regulation Advisory Council
14th Floor
600 Bay St.
Toronto, Ontario
M5G 1Z6

Mr. Charlie Bigenwald
Executive Director
Ministry of Health
Human Resources Planning Division
8th Floor, Hepburn Block

Appendix D

Ms. Sandra McCullough
Executive Secretary
(same as Ms. Jefferson)

Ms. Jody Porter
Ass. Deputy Minister
Ministry of Health
Regulated Health Professions Act
8th Floor, Hepburn Block
etc.

Mr. Alan Burrows
Director, Professional Relations Branch
Ministry of Health
7 Overlea Blvd.
5th Floor
Toronto, Ontario
M4H 1A8

The issue, if we need to go to this length, is that the proposed regulations would restrict traditional public health services. The intent of the Act was exactly the opposite. Acceptance would effectively limit public access, especially to the most needy. We attempted to clarify this with the RCDS with no satisfactory answer.

cc. Dr. R. Ellis
RCDSO

APPENDIX G:

For Use at Discussion Forum May 25, 1994, Professional Relations Branch with regard to the Dental Hygiene Act, 1991.

Although the Royal College of Dental Surgeons of Ontario feels strongly that the proposed amendment to the Dental Hygiene Act, 1991, is not in the interest of the public, it declines to participate in today's consultation session for the following reasons.

We view this request for an amendment to the Dental Hygiene Act, 1991, as a veiled attempt by the College of Dental Hygienists of Ontario to increase the Dental Hygienist's scope of practice. It is our opinion that this is inappropriate for the reasons we have set out in our written submission.

More importantly, however, we believe that this is not an appropriate forum to discuss such an amendment. We understand that the original intent of the Regulated Health Professions Act (R.H.P.A.), 1991, was to ensure that issues which may be interpreted as "turf" be dealt with by a process which, to the extent possible, is divorced from the politics of the professions. To carry out that intent, the legislature mandated that issues such as these are to be dealt with by the Health Professions Regulatory Advisory Council (H.P.R.A.C.). We maintain that the request for an amendment to the Dental Hygiene Act, 1991, is an issue which warrants consideration by the H.P.R.A.C. Consequently, in accordance with Section 12 of the Regulated Health Professions Act, 1991, we have formally requested that the Minister of Health refer this matter to the Health Professions Regulatory Advisory Council for consideration and advice. We strongly believe that, only in that arena, can the public be assured that all aspects of the issues are fully canvassed and considered.

H

PRB's SUMMARY OF ISSUES ARISING OUT OF CONSULTATIONS ON A PROPOSED AMENDMENT TO THE DENTAL HYGIENE ACT, 1991 (DHA)

During the fall of 1993, as proclamation of the Regulated Health Professions Act, 1991 (RHPA) grew near, the issue of whether dental hygienists needed an "order" from a dentist to initiate the controlled acts of scaling and root planing, including curetting of surrounding tissue became one of concern to the professions involved and to the Ministry of Health.

The dental profession expressed the belief that based on their training, hygienists were incapable of deciding appropriately whether to undertake these procedures without an order from a dentist. Hygienists, on the other hand, felt that they did not need an order because, they said, in the past they had routinely self-initiated these procedures (under "supervision").

In November 1993, the Professional Relations Branch (PRB) held joint meetings with the (then transitional) College of Dental Hygienists of Ontario (CDHO) and the Royal College of Dental Surgeons of Ontario (RCDSO). The dentists insisted on a narrow interpretation of "order" and the hygienists insisted on a broad definition of "order". No consensus could be reached despite the fact that the Ministry's position historically has supported a "broad" interpretation.

After the November meeting, CDHO developed a protocol to ensure that "orders" by dentists were documented, and sent it to all its members to present to dentists with whom they worked. A signed protocol (essentially a standing order) was deemed acceptable by the CDHO and, under acceptable conditions, by the RCDSO. However, the Ontario Dental Association (ODA) issued a notice to its members by advising them not to sign such protocols.

In March, 1994 letter, ODA advised dentists to establish their own protocols, which they claim will meet CDHO requirements without restricting the hygienists' ability to care for patients.

The outcome of this situation is that, according to an Ontario Dental Hygienists' Association survey, about 38% of hygienists in the province are working "illegally", because they do not have a signed protocol.

In early 1994, PRB was instructed by the Minister's office to carry out a process for consultation on an amendment to the DHA, using a proposal by CDHO of October 22, 1993 as the basis for discussion. PRB consultations included a meeting with the two Colleges to discuss the process, a request for comments from a broad range of stakeholders, and a one-day consultation session, held on May 25, 1994, with key parties. In all, PRB received over 170 lobby letters (Corporate Correspondence Unit has received over 100) in addition to the thirty formal submissions on this issue.

The submissions of key groups and individuals on this issue are summarized in chart form in an attachment to this memorandum. Obvious lobby letters (which outnumber submissions) from dental hygienists and dentists have been excluded from the chart for the purpose of brevity. Their letters do not add substantially to the points already being considered by PRB.

14

KEY ISSUES

The following are the key issues which have emerged from the consultations. Each issue statement is followed by comments. Conclusions and recommendations are at the end of the paper.

STATUS QUO

- **What was the "status quo" prior to the proclamation of the RHPA? Did dental hygienists routinely self-initiate these acts?**

  The CDHO has indicated that the status quo prior to the proclamation of the RHPA was as follows: a patient would come into a dentist's office; in the absence of any contraindications to treatment, the hygienist would proceed to clean the patient's teeth and then the patient would see the dentist. The hygienists claim that they routinely self-initiated scaling and root planing, including curetting.

  The dental profession has indicated that the status quo prior to the proclamation of the RHPA was as follows: a patient would come into a dentist's office, see the dentist first for a diagnosis and then be sent to the hygienist to have their teeth cleaned. The dentists claim that the patient sees the dentist first at every visit, and then sees the hygienist. One presenter, representing the Ontario Society of Periodontists claimed that she always saw her patients before the hygienist did, and stated that any dentist that proceeded differently was in the wrong.

  Based on the wide range of information received, it is PRB's view that the status quo prior to proclamation was probably somewhere between the two accounts. A new patient would, in all likelihood, see a dentist prior to seeing a hygienist, but return patients probably saw the hygienist first, and then the dentist.

  As far as self-initiation is concerned, hygienists would have operated under what could be generally termed a "standing order" (or protocol). Patients new to a practice would have to see the dentist first, but once that patient had been seen by the dentist, cleaning could proceed on the next visit, without a prior review by the dentist, except in cases where previously identified contraindications made it necessary for the patient to see the dentist first.

SELF GOVERNANCE

- **Does the need for an "order" from a dentist for a dental hygienist to perform scaling and root planing, including curetting of surrounding tissue negate self-goverance of the dental hygiene profession?**

  CDHO suggests that the need for an order interferes with the self-governance of the profession of dental hygiene.

  Indeed, the need for an order limits the role that hygienists can play in dental care, but their situation is not unique. Other health professions can only independently perform authorized acts after receiving an order of another health professional. For example, opticians may only dispense eye glasses on the prescription of an optometrist or a physician, and respiratory therapists may only perform their prescribed procedures below the dermis on the order of a physician. In neither of these cases does the need for a prescription or an order mean that the profession receiving the order is not self-regulating.

H

TRAINING

Do dental hygienists have the training necessary to assess whether they should proceed with scaling and root planing, including curetting of surrounding tissue or whether they should refer the patient to a dentist for assessment and diagnosis?

Dental hygienists are required to complete two years of community college education to receive their certificate of registration. One year of education qualifies an individual to be a dental assistant. The second year qualifies an individual as a dental hygienist.

Dentists receive four years of university training, usually following completion of at least two years of university training in general sciences or other university training. Dental specialists, such as orthodontists, receive further training.

Dental hygienists probably have enough training to allow them to assess whether the patient should be seen by a dentist prior to commencing cleaning the teeth. Hygienists are taught to take dental histories and should have enough knowledge, following their course of study, to at least be able to tell if it would be dangerous to proceed. Further, RHPA has safeguards to punish professionals who go beyond their scope of practice and cause harm.

One presenter, representing the Ontario Association of Periodontists which opposes the proposed amendment indicated that there are subtle differences between certain problems in the mouth that sometimes even dentists cannot detect. Only specialists or further tests can determine differences between a dangerous condition and one that is not. If general dentists cannot always tell the difference, it would seem unreasonable to set a higher standard for hygienists.

ASSESSMENT

Is an assessment by a dental hygienist enough, prior to initiating scaling, root planing and curetting or is a diagnosis necessary at every visit?

It would appear clear, given that there may be problems in initiating treatment, that patients who are new to a practice should always see a dentist prior to a hygienist initiating procedures on a patient. If they do not see a dentist, they should at least be pre-screened by a physician who could identify possible medical contraindications to treatment. CDHO does not contest this.

Once a patient has been seen by a dentist, there does not appear to be a strong case that they must see a dentist prior to a dental hygienist beginning work on the teeth at every visit.

Patients could be asked a series of questions about changes to their health status by the hygienist prior to the hygienist beginning work on the teeth. Any questionable changes should indicate to the hygienist that the patient should be seen by the dentist for a full diagnosis, a prescription for prophylactic medication, or other valid reason.

H

SELF-INITIATION

- **What does self-initiation mean? Is it really self-initiation of an act when a dental hygienist performs a procedure under a "standing order" or "protocol"?**

  - Self-initiation would effectively allow hygienists to proceed with planing and root scaling including curetting, without a diagnosis by a dentist or a doctor. But if prophylactic medications are required, a trip to the dentist or doctor would still be needed.

    A standing order or protocol achieves much the same outcome but reflects the fact that controlled acts, which are technically the responsibility of the profession which has a right to diagnose and prescribe a course of treatment, are often carried out by other health professionals without the direct involvement of a "supervising" health professional.

    A key point made by the dental profession that cannot be ignored is: the fact that someone is qualified to perform a procedure does not necessarily mean that the person is qualified to decide whether that procedure should be performed.

    Self-initiation allows hygienists to decide whether to perform certain acts and take full responsibility for their actions. Protocols and standing orders shift the ultimate responsibility for the patient's welfare back to the dentist (or physician), while the hygienist retains responsibility for her own performance of the acts.

PUBLIC HEALTH DENTISTRY

- **Would the lack of an amendment to the Dental Hygiene Act, 1991 really affect public health dentistry?**

  Presentations and submissions by the Ontario Society of Public Health Dentists (OSPHD) indicate that they do not believe that the lack of an amendment would seriously undermine public health dentistry in the province, as dental hygienists working in public health already operate under standing orders and they do not believe that RHPA changes that arrangement.

  OSPHD indicated a belief that public health programs were not affected, and that historical broad interpretation of a dentist's "order" could possibly resolve the problem without the need for statutory amendment.

  OSPHD indicated that they believed that regulations should be written to require the collaboration of the dentist and the hygienist, and that standing orders could be developed collaboratively by the two professions.

  It does not appear that an amendment to the DHA is critical to ensure the continued delivery of public health dental hygiene services as there are other established means of accomplishing this.

COST

- **Would it, in fact, be more cost effective if dental hygienists could practice on their own?**

The CDHO maintains that there would be a cost-effectiveness in allowing hygienists to practice independently of dentists and that this strengthens the public interest argument behind their proposal.

The general argument is that restriction of acts to particular groups of professionals reduces the supply and drives prices up. The CDHO applies this argument to dentists specifically, and maintains that allowing hygienists to self-initiate these procedures would increase supply and drive costs down.

Certainly, the laws of supply and demand would indicate that the CDHO's argument is correct in the aggregate. However, the Ministry must consider whether there would be cost savings from such an amendment in fact, not in theory. If hygienists continue to work for dentists, there would not be any cost savings because the dentist would continue to charge the same rate. Hygienists practicing on their own could presumably charge less for their services, but they would be burdened with overhead costs similar to those which face dentists.

It is also important to remember that under the RHPA there is no prohibition of the independent practice of dental hygiene. Hygienists may independently initiate their controlled acts pursuant to an order. "Supervision" by a dentist is no longer required as it was under the previous Health Disciplines Act.

Almost all dental services are paid for by the private sector. Many people belong to dental plans managed by the insurance industry, which therefore plays a key role in the finances of the dental "industry". The insurance industry is on record as favoring allowing competition by dental hygienists.

Without an independent cost-benefit analysis, it is difficult to ascertain whether any real savings would accrue from such an amendment.

ACCESS

- **Would the proposed amendment, in fact, allow more access to the health care system for low income individuals, Northern Ontario residents, etc.?**

The CDHO claims that an amendment would allow increased access to dental care by way of the fact that Northern Ontario residents would have shorter distances to travel to a dental hygienist's office, and that low income individuals who do not currently receive any dental care may see a dental hygienist.

There is no guarantee that dental hygienists would be more responsive to the need for health professionals in Northern Ontario than any other health profession.

The dental profession has argued that they have adequate representation in the North, and that allowing hygienists to practice without an "order" would put patients at unnecessary risk.

H

Lower-income individuals may see a dental hygienist rather than a dentist, but cost again becomes a factor. One particular case where the access claim may be viable would be where a hygienist was hired, on salary, by a clinic or health centre to treat low-income individuals.

DOUBLE STANDARD

- **Does "order", in fact, create a double standard in the dental hygiene profession - one for dental hygienists who work in public health care settings, and one for those who work in private settings?**

It would appear that the need for an "order" does, as currently interpreted and regulated, create a double standard within the dental hygiene profession. Public health dental hygienists follow standing orders which effectively allow them to self-initiate the disputed authorized controlled acts. Dental hygienists who work for dentists in private practice may be forced to seek an "order" every time they perform such procedures where standing orders are not used. In cases where dentists have refused to sign standing orders and refuse to provide an order for every patient, some dental hygienists are apparently working outside of their authorized controlled acts.

However, even prior to RHPA there was, in most instances, a distinction between the practice of dental hygienists in these two settings. RHPA does not essentially change the status quo -- it magnifies it.

SUPPORT BY THE PROFESSION

- **Are the majority of practising dental hygienists supportive of or opposed to the proposed amendment?**

The Ministry has received over 250 letters on this issue this year. Most of the letters have been "fill-in-the-blanks" lobby letters by hygienists in favour of an amendment. The submissions received by the Ministry from the dental hygiene profession have been largely supportive of an amendment. The submissions received by the Ministry from dentistry have been opposed to an amendment.

It is difficult to tell if the majority of the dental hygiene profession is in favour of, or opposed to an amendment. The College has certainly persisted towards the government introducing such an amendment. However, there are allegations that the "silent majority" of the profession may not be in favour of this amendment and that the current College Council does not accurately reflect the wishes of the majority of the profession. The Ministry of Health has no proof that these allegations are founded.

Without a survey of the profession by an independent agency, support for such a proposed amendment will remain unclear.

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GENDER

Is there a bona fide gender issue?

While the dentistry profession is graduating increasing numbers of women from its schools, the ratio of male dentists to female dentists is still high. The ratio of female dental hygienists to male dental hygienists is also very high.

To the extent that this issue involves predominantly male dentists "ordering" predominantly female dental hygienists, there is, in its simplest terms, a gender issue. The regulatory issue remains, however, as to whether this has any direct bearing on the issue of "order". There also exist a number of male-dominated professions which are "ordered" by other male-dominated professions.

CONSUMER PROTECTION

To what extent are consumers responsible for making their own choices about their health care professionals? To what extent must the government ensure that in making those choices, consumers are protected?

The spirit of RHPA was to allow most acts to be performed in the public domain. Acts which were considered dangerous were limited to members of particular Colleges.

Scaling and root planning of teeth, including curetting is a controlled act limited to members of RCDSO and CDHO [and the College of Physicians and Surgeons of Ontario (CPSO)].

Both dentistry and dental hygiene are authorized to perform the act, so consumers should be allowed to choose which professional they wish to have deliver their health care. The government's role is to ensure that in making a choice, the public is protected from harm. The issue at hand is whether there is sufficient risk of harm to require an "order" before the act is performed.

STANDING ORDERS

Would it still be necessary to consider amending the DHA if the dental profession agreed to have a broad interpretation of "order" under the DHA or DA or both?

The initial discussion on the "order" issue focused on a broad definition of the term order. At the time, the RCDSO did not want to consider a broad definition of "order". They have since amended their position, seemingly in light of the process of the Ministry aimed at resolving this issue.

It would be difficult to make a case for the need for an amendment if the two Colleges could agree to a broad definition of "order" that would apply in all patient care settings.

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CONCLUSIONS

- It appears that dental hygienists have enough training to treat patients on an ongoing basis. The Ministry would certainly want to ensure that any long-term course of care would be directed by a dentist initially or that a doctor was involved in pre-screening/prescribing of such things as antibiotic prophylaxis.

- If there are no contraindications to treatment, the patient should be able to choose which health care professional would proceed with cleaning on subsequent visits. Some consumers may wish to see their dentist every time. Others will choose to see the hygienist between annual checkups with the dentist.

- If hygienists are given the authority to self-initiate these procedures, it should be made a ground of professional misconduct to fail to "refer" a patient to a dentist or doctor where the hygienist believes there are contraindications to treatment. It should also be made grounds for professional misconduct to proceed with planing, root scaling and curetting if the hygienist believes there are contraindications.

- On the basis of the information gained in the consultation process, there is no specific reason that this issue must be addressed solely through an amendment to any legislation. If the two Colleges could agree on appropriate regulations, that route would probably prove more timely, given the busy legislative agenda.

Professional Relations Branch
August 26, 1994

Chart Attached.

HPRAC Referral - Chronological Background

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1991	Bill 43, Bill 47, Bill 49. With proclamation on December 30, 1993 these became respectively the Regulated Health Professions Act (RHPA), the Dental Hygiene Ac (DHA) and the Dentistry Act
3/93	Mtg: RCDS (Harding, Stein); CDHO (Mickelson, Danard, Lee, Page). CDHO informed about proposed RCDS regulation re "Order, Delegation and Assigning".
3/93	RCDS Council debates proposed regulation: "Order, Delegation and Assigning"
6/93	RCDS Council approves above regulation
6/93	CDHO circulates document "New Working Relationships..."
7/93	Mtg: RCDS (Ellis, Stein, Bromstein); CDHO (Mickelson, Page, Wagner, Ferguson
9/93	CDHO revised "New Working Relationships.." document to modify discussion of regulation re Order
9/93	CDHO circulates document "The Dental Hygienist and the RHPA", drawing attention to the danger to Public Health programs of the RCDS proposals, and calling for amndment to Bill 47
10/93	Letter: Page to Minister, proposing our draft amendment to Bill 47
10/11/93	PRB mtg: RCDS and CDHO. RCDS told by Ministry to change their policy to accep concept of a general order
25/11/93	CDHO mtg: RCDS and Pub Health Dentists. Rift between the two still apparent. RCDS policy not yet changed
20/12/93	MOH mtg: ADM and staff, Mickelson, Page, Strevens, Fulton. Possibility raised r internal PRB route to amending DHA, without referring to HPRAC
20/12/93	CDHO mtg: RCDS and ODHA - RCDS agrees to interim solution using protocols to be circulated immediately
12/93	Letter: Mickelson to Minister requesting referral to HPRAC
1/94	Ministry states intention to bypass HPRAC by doing an internal review
14/4/94	PRB mtg: RCDS and CDHO briefed re PRB public consultation process
18/4/94	Letter: Page to Citrome correcting misunderstandings apparent in his letter to Ministry re positions taken over the past year by the public health dentists
4/94	Letter: Mickelson to Minister withdrawing CDHO's request for referral to HPRAC
25/5/94	PRB public meeting; RCDS refuses to participate
5/94	RCDS requests referral to HPRAC
6/94	RCDS Council approves new regulation proposal - Standing orders (protocols) are now accepted by RCDS
6/94	CDHO circulates document "CDHO Answers Dentistry's Opposition..."
6/94	Dental profession lobbies hard to keep issue from getting on fall legislative agend Minister under pressure from opposition parties re not referring CDHO's amendment proposal to HPRAC
7/94	RCDS withdraws request for HPRAC referral
8/94	PRB reports to Minister on public consultation.
8/94	CDHO renews request for referral to HPRAC
9/94	Minister refers question of amending DHA to HPRAC with 30Apr95 report deadlin
10/94 - 11/94	Correspondence between HPRAC and Minister clarifying basic issues to be dealt with - public safety, etc
12/94	HPRAC meets with RCDS and CDHO individually to review the process - asks Colleges to develop joint letter outlining their areas of agreement and disagreemer
22/12/94	CDHO meets with RCDS to develop joint letter - very limited success
27/12/94	HPRAC circulates questions to stakeholders and interested groups
1/95	CDHO steering committee begins developing comprehensive response to HPRAC
19/1/95	CDHO circulates "The Proposed Amendment to the Dental Hygiene Act" - a reques for support from consumer groups